

101-44

**FISCAL YEAR 1990 BUDGET ISSUES RELATING TO
PAYMENT OF INNER-CITY AND RURAL HOSPI-
TALS UNDER PART A OF THE MEDICARE PRO-
GRAM**

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS

HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

MAY 15, 1989

Serial 101-44

Printed for the use of the Committee on Ways and Means



U.S. GOVERNMENT PRINTING OFFICE

22-425

WASHINGTON : 1989

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

Y4.W36:

READEX
FICHE

best copy available

COMMITTEE ON WAYS AND MEANS

DAN ROSTENKOWSKI, Illinois, *Chairman*

SAM M. GIBBONS, Florida	BILL ARCHER, Texas
J.J. PICKLE, Texas	GUY VANDER JAGT, Michigan
CHARLES B. RANGEL, New York	PHILIP M. CRANE, Illinois
FORTNEY PETE STARK, California	BILL FRENZEL, Minnesota
ANDY JACOBS, Jr., Indiana	DICK SCHULZE, Pennsylvania
HAROLD FORD, Tennessee	BILL GRADISON, Ohio
ED JENKINS, Georgia	WILLIAM M. THOMAS, California
RICHARD A. GEPHARDT, Missouri	RAYMOND J. McGRATH, New York
THOMAS J. DOWNEY, New York	HANK BROWN, Colorado
FRANK J. GUARINI, New Jersey	ROD CHANDLER, Washington
MARTY RUSSO, Illinois	E. CLAY SHAW, Jr., Florida
DON J. PEASE, Ohio	DON SUNDQUIST, Tennessee
ROBERT T. MATSUI, California	NANCY L. JOHNSON, Connecticut
BERYL ANTHONY, Jr., Arkansas	
RONNIE G. FLIPPO, Alabama	
BYRON L. DORGAN, North Dakota	
BARBARA B. KENNELLY, Connecticut	
BRIAN J. DONNELLY, Massachusetts	
WILLIAM J. COYNE, Pennsylvania	
MICHAEL A. ANDREWS, Texas	
SANDER M. LEVIN, Michigan	
JIM MOODY, Wisconsin	

ROBERT J. LEONARD, *Chief Counsel and Staff Director*
PHILLIP D. MOSELEY, *Minority Chief of Staff*

SUBCOMMITTEE ON HEALTH

FORTNEY PETE STARK, California, *Chairman*

BRIAN J. DONNELLY, Massachusetts	BILL GRADISON, Ohio
WILLIAM J. COYNE, Pennsylvania	ROD CHANDLER, Washington
J.J. PICKLE, Texas	PHILIP M. CRANE, Illinois
BERYL ANTHONY, Jr., Arkansas	NANCY L. JOHNSON, Connecticut
SANDER M. LEVIN, Michigan	
JIM MOODY, Wisconsin	

CONTENTS

	Page
Press release of Tuesday, May 2, 1989, announcing the hearing	2
WITNESSES	
U.S. Department of Health and Human Services, Richard P. Kusserow, Inspector General.....	40
Alameda County Health Care Services Agency, David J. Kears.....	147
American Hospital Association, Michael Anthony	118
Bernstein, James D., North Carolina Department of Human Resources	179
Boufford, Jo Ivey, M.D., National Association of Public Hospitals	134
Codman Research Group, Inc., S. Philip Caper, M.D.....	163
Community Hospital Onaga, Inc., Onaga, Kans., Joseph T. Engelken.....	194
Dorgan, Hon. Byron L., a Representative in Congress from the State of North Dakota	16
Dougherty, Cary M., Jr., Medical Center of South Arkansas.....	202
Engelken, Joseph T., Community Hospital, Onaga, Inc., Onaga, Kans.....	194
Flippo, Hon. Ronnie G., a Representative in Congress from the State of Alabama	6
Kears, David J., Alameda County Health Care Services Agency.....	147
McNulty, Molly, National Health Law Program.....	101
Medical Center of South Arkansas, Cary M. Dougherty, Jr.....	202
National Association of Public Hospitals, Jo Ivey Boufford, M.D.....	134
National Health Law Program, Molly McNulty	101
New York City Health and Hospitals Corp., Jo Ivey Boufford, M.D.....	134
North Carolina Department of Human Resources, James D. Bernstein	179
Rosenberg Associates, Bolinas, Calif., Steven Rosenberg	186
Slattery, Hon. Jim, a Representative in Congress from the State of Kansas	27
Synar, Hon. Mike, a Representative in Congress from the State of Oklahoma ..	21
Tauke, Hon. Thomas J., a Representative in Congress from the State of Iowa ..	24
SUBMISSIONS FOR THE RECORD	
Illinois Hospital Association, statment.....	235
National Committee to Preserve Social Security and Medicare, Martha McSteen, statement	237
National Federation of Housestaff Organizations, David Daigneault, M.D., statement.....	239



**FISCAL YEAR 1990 BUDGET ISSUES RELATING
TO PAYMENT OF INNER-CITY AND RURAL
HOSPITALS UNDER PART A OF THE MEDI-
CARE PROGRAM**

MONDAY, MAY 15, 1989

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The subcommittee met, pursuant to call, at 1 p.m., in room 1100, Longworth House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

(1)

FOR IMMEDIATE RELEASE
TUESDAY, MAY 2, 1989

PRESS RELEASE #12
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE FORTNEY PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES A HEARING ON FISCAL YEAR 1990 BUDGET ISSUES RELATING TO
PAYMENT OF INNER-CITY AND RURAL HOSPITALS
UNDER PART A OF THE MEDICARE PROGRAM

The Honorable Fortney Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a hearing on fiscal year 1990 budget issues relating to payment of inner-city and rural hospitals under Part A of the Medicare program. The hearing will be held on Monday, May 15, 1989, beginning at 1:00 p.m., in the main Committee hearing room, 1100 Longworth House Office Building.

In announcing the hearing, Chairman Stark said: "Inner-city and rural hospitals face difficulties in responding to the changes in the health care delivery system. The Subcommittee needs to explore the factors causing these problems, as well as changes in Medicare reimbursement policy which may help to resolve them."

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

BACKGROUND

Concerns have been raised about the financial status of inner-city and rural hospitals.

For inner-city hospitals, the high levels of indigent care provided by these hospitals, inadequate reimbursement by some State Medicaid programs, and higher costs due to their inner-city locations have been cited as factors leading to financial difficulties for these hospitals.

In the case of rural hospitals, concern has been expressed about Medicare's rural standardized amount and the application of the wage index to hospitals in rural areas. In addition, volume is dropping for small rural hospitals. New research indicates that Medicare beneficiaries in rural counties may be seeking care at nearby urban hospitals. The resulting loss in revenue for rural hospitals is a significant contributing factor to the problems facing these hospitals.

Medicare's prospective payment system (PPS) pays differential amounts to urban and rural hospitals based upon the average costs incurred by these hospitals after adjustments for case mix and labor costs. In addition, hospitals which serve a disproportionate number of low-income beneficiaries and Medicaid beneficiaries receive a disproportionate-share adjustment. Inner-city hospitals receive the bulk of payments related to the disproportionate-share adjustment.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Friday, May 12, 1989, to Robert J. Leonard, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

SEE FORMATTING REQUIREMENTS BELOW:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

Chairman STARK. The Health Subcommittee of the Committee on Ways and Means will begin its hearing today on the payment of rural hospitals under the Medicare Program. We will focus on those problems that were reported by the inspector general of the Department of Health and Human Services and also some interesting testimony from our colleagues in the House.

The subcommittee has approached this process with two goals: To try to promote the efficiency of the hospital system, and, as our first priority, to try to protect and support those hospitals providing care for the poor and medically indigent.

Promoting efficiency means we have attempted to assure that Medicare will reimburse leanly but fairly to those well-run and efficient hospitals. It doesn't mean that every hospital will get all the money it would like, nor does it mean that every hospital can make a profit on Medicare. Not all hospitals are equally able to efficiently produce services for the Medicare population. Those with high occupancy and relatively lower costs make money and the others don't.

This is precisely the point of the prospective payment system put in place 5 or 6 years ago. However, there are some hospitals with special circumstances with which we must be concerned. Inner-city hospitals serving the poor deserve consideration as do the rural hospitals which are the sole providers of care for a large area. The problems in these hospitals are often inaccurately linked.

In fact, they stem from very different problems. One is the lack of payment; the other, in rural areas, is basically the lack of patients. We must protect and support those inner-city institutions, which provide care for the poor and indigent, and we should not expect to reduce the budget deficit at the expense of these safety net hospitals, given the increase in bad debt, charity care which they are experiencing.

We must increase special assistance to them through the disproportionate share adjustment. I am pleased that we will hear today from the director of the Alameda County CA Health Department. Alameda County is my district. It has hired an ethicist to help make choices about which services indigent patients will receive and which they will not.

This is the first time, to my knowledge, and I am not very proud of it, that we are all paying someone to point to this person and say you get care and point to someone else and say you don't. Why? Because we just don't have enough money to provide the services. It is easy to be horrified that a county feels compelled to make those choices, but I would argue it is an outgrowth of the unwillingness of the State of California to adequately fund its health care programs. Moreover it is a reflection of the failure of all of us to address the need to find ways to extend health insurance protection to every American.

In the interim, we can't turn our backs on the struggle which these hospitals face every day. We will also focus on legislation that I am going to introduce—the Medicare Hospital Patient Protection Amendments of 1989—which protects hospital patients from improper transfers for economic returns.

This is generally called dumping. My bill builds on prior legislation that we have introduced in the Congress as an alternative to

ensure that patients in need of emergency care are not bounced from one hospital to the other. Problems of rural hospitals will occupy a large part of our hearing.

In that regard we are fortunate to be joined by a number of Members of the House to address this issue. In particular, I am pleased that representatives of the rural health caucus will testify today. Problems of rural hospitals will not be resolved simply by throwing money at them.

Unfortunately more money will not buy more patients. Research which will be presented today shows rural citizens are voting with their feet and seeking less and less of their hospital care at their local rural hospital. This suggests, just as we needed to consolidate the rural high schools in the 1960's, we also need to consolidate our rural hospitals in order to ensure access and up-to-date high-quality care.

I am working with my colleagues on the subcommittee to develop a proposal that would provide for enhanced reimbursement of consolidated hospitals, and secondly, support the establishment or conversion of present hospitals to comprehensive rural health centers in communities where hospitals cease providing patient care or can no longer provide it and remain financially viable.

I hope our discussion today will not get bogged down in the discussion about the equity of the rural versus the urban payment. I hope that we can look at ways to ensure cost-effective access to health care in rural America, and we must all work together to design the specific steps we need to take to ensure that rural Americans receive the high quality of care they need.

I look forward to that discussion. I would like to say to my colleagues from the rural areas that I would be remiss if I didn't bring into focus the politics of the problems we face.

None of us likes to go home and close a post office or a military base or a hospital. We just don't like to bear bad news, and I, for one, wouldn't ask any of my colleagues to say why don't you go home to close a hospital or close a post office.

On the other hand, if we just thought that raising the price of the procedures Medicare pays for by itself would do anything, and believe me it won't, in most hospitals we could triple the price that you get for an appendectomy or a bypass procedure and it still wouldn't save the hospital. So I think what our committee is going to be looking for is to spend more money in the rural sector of medical care delivery. Can we find a way that also solves the problem and just doesn't continue to spend more money to watch certain hospitals close?

Our first witness today is the Honorable Ronnie J. Flipppo, a member of the House Ways and Means Committee from Alabama, best known for being the home of Huntsville and its work with NASA. Mr. Flipppo was elected in the 95th Congress and now serves his seventh consecutive term. He is a member of the Subcommittee on Select Revenue Measures of our distinguished committee and it is a joy to have you.

Ronnie, would you like to proceed?

STATEMENT OF HON. RONNIE G. FLIPPO, A REPRESENTATIVE IN
CONGRESS FROM THE STATE OF ALABAMA

Mr. FLIPPO. Thank you, Mr. Chairman. I would like to ask that my statement be included in its entirety, and I understand the need for brevity. I shall summarize.

Chairman STARK. Without objection, it will be included and your brevity will be appreciated by your brethren behind you.

Mr. FLIPPO. Thank you.

Mr. Chairman, first of all I want to express my gratitude to you and the members of the subcommittee for the extensive hearings that you have held this year. They are extremely important. They are shedding a great deal of light on the entire Medicare Program. They have been helpful to me and I am sure to my colleagues.

I am grateful for the opportunity to appear before you. I want to tell you also that the staff of your distinguished committee has been extremely helpful. They have visited my district. They have talked with my constituents in Washington and have been most cooperative in helping us in getting all the facts about the Medicare problem.

My purpose in being here this morning, Mr. Chairman, is to report to you on the condition of the 59 hospitals in the State of Alabama, and I believe that their condition may, in fact, be representative of the rural hospitals in America, and the disturbing trends that we are experiencing there.

The truth of the matter in the short and most concise statement, Mr. Chairman, is that rural hospitals are closing in Alabama and throughout the country. This is creating an enormous crisis in the rural communities. Alabama has the highest hospital closure rate in the Nation. In 1987—1980 to 1987 Alabama had nine hospitals close. In 1988 alone 7 hospitals closed, and it is estimated by the Alabama Hospital Association that before 1989 is over between 7 and 13 additional hospitals will close in the State of Alabama.

The results of that, Mr. Chairman, is that thousands of Alabama citizens are without readily accessible medical care. Several entire counties have no hospitals at all.

There are many reasons for that, as the chairman has discussed, but one of the main reasons is this. In 1987 earnings of these rural hospitals declined approximately 11 percent in that year. In fact, 82 percent of these hospitals lost money during 1987, due to causes, which the chairman has also pointed out. ProPAC has also stated that among the causes of the stress in the rural hospitals is an aging population, eroding patient base, changing rural economics.

The economic expansion of the 1980's, Mr. Chairman, really did pass by rural America. Rural America has not really recovered from those recessions that we experienced in the early 1980's. Rural America is today characterized by high unemployment, by the migration of youth to cities, by declining infrastructure, and I might say that there have been no programs proposed by the Federal Government, by the administrations over the last 10 years for assistance to rural America.

In fact, we have seen attack after attack on those programs that provide the support base in rural America. While there are many reasons for the problem, Mr. Chairman, the hospital administrators

in my State contend that the major cause of problems facing rural hospitals today is that Medicare prospective payment system.

The system they contend is based on theory, on the law of large numbers or on deteriorating of averages. For hospitals that serve large numbers of patients, the system has, apparently for the most part, worked, but for hospitals without the benefit of great numbers of patients, PPS has meant slow starvation.

Under this system of averages, rural hospitals receive lower rates than urban hospitals, usually 25 to 35 percent less, but sometimes as much as 50 percent less, and the rationale behind the different rates is that on the average hospital services provided by rural hospitals cost less than hospital services provided by urban hospitals because urban hospitals treat sicker patients than rural hospitals.

Mr. Chairman, I have come to believe that a payment system like PPS, however, just doesn't work for rural hospitals. The system discriminates against these hospitals by paying lower rates for an inpatient service in a rural hospital than that paid for the same service in an urban hospital.

Another factor impacting on Alabama's hospitals is the delivery of uncompensated care. Simply put, uncompensated care is wreaking havoc on Alabama's hospital financial health, especially in our rural communities. In 1987 alone Alabama hospitals collectively absorbed over \$260 million worth of uncompensated care at actual cost or more than 12 percent of their total expenses.

Another contributing factor to the crisis in rural health care in Alabama is the lack of adequate obstetrical services available for pregnant women. Although benefits of prenatal care are obvious, many barriers exist between this care and the patient. Access to care is the most significant problem. Currently 28 counties in Alabama are without obstetrical services, a trend which will only worsen over time, especially in Alabama's rural areas.

The maldistribution of obstetricians in urban centers will continue as more rural hospitals are forced to close their doors. Mr. Chairman, the prospective payment system appears to be biased against rural hospitals. Medicare inpatients and PPS payments are not distributed equally among hospitals.

According to ProPAC, urban hospitals account for about half of the PPS hospitals, but they receive 83 percent of Medicare payments. Their payments average 40 percent more for each case. In addition, urban hospitals get 98 percent of added payments for teaching, 96 percent of disproportionate share payments, and 90 percent of outlier payments.

Mr. Chairman, the Federal budget that we now have under consideration makes all of us sensitive to the need to control soaring medical costs while protecting Medicare beneficiaries from higher deductibles. But it seems to me if we want to control hospital costs that we need to concentrate on the group of hospitals that are getting 83 percent of the payments.

I believe, Mr. Chairman, that the time has come for a change, a comprehensive change in Medicare payments to rural hospitals, and I have cosponsored along with my colleague, Mr. Pickle, a bill, H.R. 762, to eliminate the urban-rural payment differential and support financially distressed rural hospitals.

The legislation would eliminate the existing differential between Medicare payment rates for urban and rural hospitals in favor of a single national rate which will apply to all hospitals to be phased in over a 4-year period. To provide immediate relief for the most vulnerable rural hospitals, our bill would allow hospitals with fewer than 100 beds and that depends on Medicare for 70 percent or more of their revenue to be paid at least their reasonable costs.

This provision would go a long way to ease the financial squeeze that rural hospitals are now experiencing. Mr. Chairman, Alabama's rural hospitals have responded to changes in the health care financing system in many ways. To cut costs they have closed unused beds. They have laid off unnecessary staff. They have reduced the time that patients are hospitalized, and they have increased out-patient services, but many small rural hospitals will still have difficulty making further cuts without reducing the necessary services.

Hospital budgets have already been cut so slim that continued demands for cost reduction will certainly affect care. Cost cutting alone is not the sole solution to our problems in this area. Mr. Chairman, please don't misunderstand me. I am not advocating institutional support just to guarantee institutional survival, but what will happen when access to health care without these facilities in the rural areas of our Nation. On behalf of the 59 struggling rural hospitals and rural communities in Alabama, I urge you and the subcommittee to take action now to ease the crisis in rural health care.

Thank you very much for the opportunity to appear here today.
[The statement of Mr. Flipppo follows:]

STATEMENT OF THE HONORABLE RONNIE FLIPPO
BEFORE THE SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS

Thank you Mr. Chairman and members of the Subcommittee for providing me this opportunity to appear before you today.

First of all, I want to commend you Mr. Chairman and the Subcommittee members for holding this hearing today and for the series of hearings you have held so far this year. These hearings have focused attention on virtually every aspect of the Medicare funding crisis. They have provided valuable testimony that has been very helpful to this member and I believe, every member of the full committee.

Mr. Chairman, I also want to commend the subcommittee staff for the assistance they have provided me. They have been most gracious and generous in fulfilling my requests for facts and information. As you know Mr. Chairman, members of your staff have visited my district and have met with my constituents in Washington. These meetings have been very helpful for me and the health care providers in Alabama.

My purpose in being here today Mr. Chairman, is to bring to your attention the disturbing trends among the rural hospitals in Alabama. To let you know how the 59 rural hospitals in Alabama have been affected by health policy changes and developments over the last few years.

Alabama may be a good state for the subcommittee to examine in detail because of the rural nature of our state and because Alabama's rural hospitals have historically been some of the lowest cost facilities in the country. The reaction of our rural facilities to changes in federal health care policy may therefore be a good bellwether for gauging problems in rural facilities as a class of hospitals.

I wish the picture were brighter in Alabama, Mr. Chairman. There is a crisis in Alabama's rural communities today, a crisis regarding access to quality health care services. The primary focus of many communities' health care, the rural hospital, is in jeopardy of disappearing in many areas.

These are hard times for rural areas. We have in our part of the country a growing number of the poor, the unemployed, and the elderly. These people depend on their community hospitals. The elderly population in particular is known to absorb a significant amount of health care services. But if these rural hospitals don't get some relief from the economic pressures confronting them they may not be around much longer.

Rural hospitals are the key to a strong rural health care system. In addition to basic acute care, these hospitals are often the locus in their community for home health services, respite care, nursing care, preventive health and well-child clinics, and other health services. They are essential to attracting and retaining physicians and other health professionals in rural areas.

The importance of rural hospitals goes beyond that though. Most are more than just a place to receive medical attention. They are an integral part of their respective communities. Some are landmarks. Many are major employers. Collectively, the hospitals in my home state of Alabama employ over 8,400 and have an economic impact on our state of over \$2.3 billion annually.

When the local hospital closes, the community loses a lot more than just a hospital. Ultimately, the whole community suffers.

Inadequate reimbursement granted to hospitals for Medicare patients can ultimately raise concerns about quality and access to health care as reduced payment rates force hospitals to cut down on staff and close unprofitable services. This is particularly troublesome for rural hospitals. The possibility of numerous closures is becoming a reality across the country.

Closures of rural hospitals continue to grow at an alarming rate. There is a growing and understandable fear that should additional facilities close that access to health care services in rural areas will be "jeopardized."

Alabama has the highest hospital closure rate in the nation.

Between 1980 and 1987, nine Alabama hospitals closed; four were urban facilities, five were rural facilities. In 1988, seven more hospitals closed; three were urban facilities, four were rural facilities. The magnitude of these hospital closures have been felt--thousands of citizens are without readily-accessible medical care and several entire counties in Alabama are without a hospital at all. The Alabama Hospital Association estimates that seven to thirteen more hospitals may close in 1989.

In Alabama, 59 of the 145 hospitals are rural. The majority of these rural hospitals have less than 50 beds. In addition to having fewer beds, these hospitals treat a higher percentage of patients who are elderly, people whose illness tend to be more acute, resulting in more costly care. The volume of this type of patient, coupled with the intensity of care required, in turn makes these hospitals much more dependent on the Medicare system for their survival than other hospitals.

Data from the Alabama Hospital Association indicate that their members located in rural areas experienced an operating loss of -11.0% in 1987. In fact, 82% of the rural hospitals in Alabama experienced a loss during that time period; only 18% had any kind of operating margin at all. Net income from patients in all Alabama hospitals, based on income statements included in Medicare cost reports which were filed by 111 hospitals in the 1987 calendar year, was -1.0% of gross patient revenue. Only 35 of the 111 hospitals analyzed earned an operating profit while 75 incurred net operating losses. The fact is, the average Alabama hospital incurred a loss from services to patients of -1.0% for its 1987 fiscal year.

There are a variety of reasons for the precarious situation in which our rural hospitals find themselves. As compared to their urban counterparts, rural hospitals tend to be smaller, have fewer patients, lower costs, fewer specialized areas, and often serve a population older than average. Rural hospitals treat fewer private-paying patients and treat a disproportionately high percentage of Medicare patients. The dependence on Medicare as a major payment source has become particular concern since the implementation of the prospective payment system (PPS) in 1983.

Other contributing factors exist. In their March 1989 report to Congress, the prospective Payment Assessment Commission (PROPAC) stated that "the demographic and economic environment of rural communities is changing. An aging population, eroding patient base, and changing rural economy are among the forces influencing the long term viability of rural hospitals."

The economic and demographic changes in rural America in the 1980's has been profound. The economic expansion of the 1980's has bypassed rural America. The rural areas have not recovered from the deep recession of the early 1980's. Rural America is marked by high unemployment, migration of the young to the cities

and a declining infrastructure. The Administration has failed to provide any meaningful programs, assistance or direction to help rural America for almost ten years.

Hospital administrators in my state contend that the major cause of the problems facing rural hospitals today is Medicare prospective payment system. The system they contend is based on theory, on the law of large numbers--the "tyranny of averages." For hospitals that serve large numbers of patients, the system has, for the most part, worked. But for hospitals without the benefit of great numbers of patients, PPS has meant "slow starvation."

Under this system of averages, rural hospitals are paid lower rates than urban hospitals, usually 20-35% less, but sometimes as much as 50% less. The rationale behind the different rates is that, on average, hospital services provided by rural hospitals cost less than hospital services provided by urban hospitals because urban hospitals treat sicker patients than rural hospitals.

I am coming to believe that a payment system like PPS however, just doesn't work for rural hospitals. The system discriminates against these hospitals by paying lower rates for an inpatient service in a rural hospital than paid for the same service in an urban hospital. Because of their small size and the large number of Medicare beneficiaries these hospitals are unable to be compensated adequately for the low Medicare payment provided for each case. They cannot adjust easily to fluctuations in inpatient admissions or case mix, whereas larger hospitals can average the fluctuations from year to year and over many cases.

For small rural hospitals, which tend to operate closer to the margin, these fluctuations can be devastating financially. Forty percent of Alabama's small, rural hospitals patients are Medicare beneficiaries; 47% of these hospitals' total patient days are for Medicare patients. Clearly, rural hospitals are at risk when the payment system fails to compensate them adequately for their special circumstances or when inequities in payment policies exist.

Another major factor impacting on Alabama's hospitals is the delivery of uncompensated care (non-payment for medical services rendered). Simply put, uncompensated care is reaping havoc on Alabama hospitals' financial health, especially in our rural facilities. In 1987 alone, Alabama hospitals collectively absorbed over \$260 million worth of uncompensated care at actual cost, or more than 12% of their total expenses.

The uncompensated care crisis is particularly critical for Alabama's small, rural hospitals because they treat a high percentage of indigent and elderly patients. To illustrate--in 1987, a rural Alabama hospital had an uncompensated care patient who--because of a secondary condition eventually was transferred to another hospital for specialty care. That patient's final bill was more than the entire operating budget of the rural hospital which had originally admitted him.

Another contributing factor to the crisis in rural health care in Alabama is the lack of adequate obstetrical services available for pregnant women. Although the benefits of prenatal care are obvious, many barriers exist between this care and the patient. Access to care, however, is the most significant problem. Currently 28 counties in Alabama are without obstetrical services, a trend which will only worsen over time, especially in Alabama's rural areas. The maldistribution of obstetricians in urban centers will continue as more rural hospitals are forced to close their doors.

Alabama had the dubious distinction of leading the nation in the number of infant deaths in 1986. In 1987, we improved

somewhat from 13.3 deaths per every 1,000 live to 12.2 deaths per 1,000 live births. Sadly though, according to recent statistics Alabama still ranks fourth in this indicator of our nation's health. In my opinion, a significant contributing factor to this distressful situation is lack of access to care in poor, rural areas.

When the Medicare PPS was enacted, we were not aware of many of the difference between rural and urban hospitals that might adversely affect their financial viability. Since that time, we have made several very important modifications in the payment formula which have somewhat lessened the severity of the payment differential between urban and rural hospitals. More must be done however, especially on the issue of an adequate and equitable payment increase for FY90.

The Medicare Prospective Payment System appears to be biased against rural hospitals--Medicare inpatients and PPS payments are not distributed equally among hospitals. According to the Prospective Payment Assessment Commission (PROPAC), urban hospitals account for about half of PPS hospitals, but receive 83% of Medicare payments. Their payments average 40% more for each case. In addition, urban hospitals get 96% of added payments for teaching, 96% of disproportionate share payments, and 90% of outlier payments. (Source: "Medicare Prospective Payment and the American Health Care System, Report to the Congress," Prospective Payment Assessment Commission, June, 1988.)

Mr. Chairman, the federal budget we now have under consideration makes us all sensitive to the need to control soaring Medicare costs while protecting Medicare beneficiaries from higher deductibles. However, it seems to me that if we want to control hospital costs, we need to concentrate on the group of hospitals that are getting 83% of the payments, and not on the group that's only getting 17%.

I believe that the time has come for a change--a comprehensive change--in Medicare payments to rural hospitals. I have cosponsored legislation, the Equity for Rural Hospitals Act of 1989 (H.R. 762), with my distinguished colleague, Representative J. J. Pickle, to eliminate the urban/rural payment differential, and support financially distressed rural hospitals. This legislation takes a balanced, thoughtful approach to reforming Medicare hospital payments in an equitable manner over the next few years, and provides immediate relief for struggling rural hospitals.

This legislation would eliminate the existing differential between Medicare payment rates for urban and rural hospitals in favor of a single national rate which will apply to all hospitals, to be phased in over a period of four years. The elimination of the urban/rural payment differential is a necessary step in ensuring equitable and adequate payment for all hospitals.

The bill would require the Secretary of the Department of Health and Human Services (HHS) to conduct an analysis of each special feature of PPS and to develop a legislative proposal that would treat urban and rural hospitals equitably while giving recognition to the legitimate cost differences among facilities. The report would be due to Congress in 1991, allowing sufficient time for both the Prospective Payment Assessment Commission (PROPAC) and the Congressional Budget Office to review its findings, and give us a better understanding of the current system's shortcomings in reimbursing all hospitals, urban and rural.

To provide immediate relief for the most vulnerable rural hospitals, our bill would allow hospitals with fewer than 100 beds that depend on Medicare for 70% or more of their revenue to be paid at least their reasonable cost. This provision would go a

long way to ease the financial squeeze that rural hospitals are now experiencing.

Some rural hospitals have been forced to close their doors because they cannot retain their qualified health care personnel, losing labor resources to more generously compensated urban hospitals located nearby. H.R. 762 would create a Medicare Geographic Classification Review Board which would examine the requests of rural border hospitals who believe they are unfairly treated by Medicare.

The legislation would also expand on two demonstration projects created in the 1987 budget reconciliation bill which have been of great interest to rural hospitals in Alabama. Rural transition grants will be awarded to about 90 rural hospitals to encourage managers to look for innovative ways to modify the type of services they deliver to improve service to their communities. I understand that the Alabama Hospital Association has filed a letter of intent to submit application for a rural health care transition grant on behalf of rural hospitals that qualify in the state.

However, many hospitals will be unable to qualify because the program received only \$8.9 million in FY89, although \$15 million was authorized. Under H.R. 762, the program's authorization would be extended through FY92 and increased to \$25 million annually. H.R. 762 would also increase funding for rural health medical education and nurse graduate education demonstration projects. The legislation is a good first step to preserve the rural health care system and the very existence of many rural hospitals.

Mr. Chairman, Alabama's rural hospitals have responded to the changes in the health care financing system in many ways. To cut costs, they have closed unused beds, laid off unnecessary staff, reduced the time patients are hospitalized and increased outpatient services. However, many small, rural hospitals will have difficulty making further cuts without reducing necessary services. Hospital budgets have already been cut so slim that continued demands for cost reductions could affect quality of care. Cost-cutting alone is not the answer to long term financial viability for rural hospitals.

If we don't act quickly to change Medicare's PPS, the health care system in rural America will crumble. If that happens, we will be forced to take a drastic measure--with a drastic price tag--to rebuild it. That would be a serious mistake.

Action is needed now to alleviate the current crisis in our rural health care industry--a crisis that threatens the viability of many of our rural hospitals. Further adjustments to the system must be made to build upon current law and further address the needs of rural hospitals. We must do all that we can to insure that our citizens in rural communities will have access to these services in the future. After all, that is our goal--access to care.

Don't misunderstand me, I am not advocating institutional support just to guarantee institutional survival, but what will happen with access to health care without these facilities in the rural areas of our nation? On behalf of the 59 struggling rural hospitals and rural communities in Alabama, I urge you and the Subcommittee to take action now to ease the crisis in rural health care.

Thank you.

Chairman STARK. Thank you. One thing we tend to get into a little bit of a numbers game and I hope none of you will sink to the level of the American Hospital Association. The inspector general will testify somewhat later and give us some numbers on 1987 hospital closures. In Alabama in 1987, according to his figures, 13 hospitals closed, and that's not an insignificant number.

Only 37 rural hospitals closed nationwide, but the 3 were Guin?

Mr. FLIPPO. Guin, yes.

Chairman STARK. Livingston-Tombigbee in Livingston and Jo Enru Community in Tuskegee Institute. Now, I don't know anything about those hospitals, but the inspector general will tell us and this is where I would appreciate knowing this, that basically those hospitals, if they are anywhere near the average, probably never had more than approximately 10 beds occupied all year and a small percentage, may be less than half, maybe 30 percent or less, were Medicare patients.

I know your skill as an accountant. My guess is if you went back and looked at a couple of years prior to those hospitals closing, and here is the dilemma that we are faced with, is even had we paid them two or three times the Medicare reimbursement that they might pay to a hospital in Birmingham, they would still have gone broke.

Now you are suggesting that we just support them by giving them all their costs. Then the inspector general will tell us that there are very few hospitals, and this has to be done, I suppose, on a special basis, are more than 20 miles away from another one, and that is politically not very good for the people who are a mile away because they don't like to go to the neighboring town and they have been losing to them in baseball all these years.

Now, they don't want to have to go there and beat on somebody but they really were fairly close by modern day transportation standards. I think urban hospitals are doing the same thing. They closed as many urban hospitals the same year and most of them were under 25-bed urban hospitals, and they closed for the same reason.

People weren't going there. They were going to the bigger hospital down the block.

The question is, which ones, if any, should close, and that's the problem. I know where they should close. They should close in Arkansas, not Alabama. Obviously, I can understand. Or in California. But what can we do that's acceptable to you and would have been acceptable to those three cities for some kind of alternative service?

If we can figure that out, I think we could then say, OK, the units ought to stay open and we ought to pay whatever it costs to keep them open, but I don't think we can afford to do that for every hospital, and that is our problem.

How do we decide which one becomes the emergency room and transfers patients to a unit 10, 20, 30 miles away and gets a helicopter, and which one becomes the hospital we support that has the modern facilities? How do we decide that?

Mr. FLIPPO. Well, the statements, Mr. Chairman, brings about a very difficult point as to how to approach that, but I would say

the chairman that 1987 is not a very typical year. The gentleman took whatever figures he had from the inspector general for 1987 and quoted three; 1988 may be more representative of the impact of the implementation of the PPS system.

Chairman STARK. You had seven that have closed then?

Mr. FLIPPO. Seven closed in 1988. And then coming off that one of the things that we can do, Mr. Chairman, we must let the market tell us which to close, but we need to let the market tell which to close after we treat them all fairly, after we treat them all fairly in terms of not discriminating against them, in terms of paying something for a rate for a type of service in a rural area versus the other.

The whole theory behind the fact that urban hospitals are treating sicker patients as our population ages in the rural areas, the distinguished chairman surely knows that the older patients require far more intensive care. In fact, that's where they absorb the most cost, and so my plea is for equity in the reimbursement and then if the reimbursement is not there—

Chairman STARK. But let's take another example. Let's pay them more than fair. Let's pay them 50 percent more than fair, and then if you take their books and show that they still can't stay open, why waste the money?

I am perfectly willing to add extra money to rural and inner-city hospitals, but I hate to keep doing it every year and yet they keep closing every year. Some of that money is getting wasted if we can't find a better way.

I agree with you, they should get a fair rate, but I don't think they can all get it. We can't afford even that to keep them all open. That is my dilemma. If you could help—we will get the money to them, but somehow we have to decide which ones have to be kept open on some kind of empirical formula and how do we provide service to those people who have to look for a different pattern of medical care delivery.

Mr. FLIPPO. I look forward to working with the chairman for a solution. I thank the gentleman for his consideration.

Chairman STARK. Thank you very much. I didn't mean to argue so much with my colleague, but I did want the subsequent panel members to hear our dialog because it is a problem that this subcommittee has gone through every year, and that is not only how do we keep rural hospitals from closing, but should we, and if so which ones? I am pleased to welcome a panel of four distinguished members who I am sure will shed a great deal of light on that problem.

The panel consists of the Honorable Byron Dorgan of North Dakota, also a member of the Committee on Ways and Means, representing North Dakota's single at-large district. He was elected in 1980 after a distinguished career as North Dakota's tax commissioner, and is now serving his fifth term.

He serves on the Oversight and Select Revenue Subcommittees of the Committee on Ways and Means, and on the Select Committee on Hunger. He is joined by the Honorable Jim Slattery of Kansas, who represents the Second District of Kansas, Topeka and Lawrence, home of the University of Kansas.

He was elected to the 98th Congress and now serves his fourth term as a member of the Committee on Energy and Commerce, with whom we share jurisdiction on many of these problems, the Committee on the Budget who give us our marching orders how to solve these problems.

He is joined also by the Honorable Mike Synar of Oklahoma, cochair of the Rural Health Care Coalition. Mike represents Second District of Oklahoma, including the city of Muskogee in northern part of the State.

He was elected in 1978 and is a member of the Committee on Energy and Commerce, the Committee on Government Operations, the Committee on the Judiciary and the Select Committee on Aging. In between, he takes the time to come and testify for us. We appreciate that.

The fourth member of the panel is the Honorable Thomas Tauke of Iowa, the cochair of the Rural Health Care Coalition. Mr. Tauke represents the Second District of Iowa, including the communities of Dubuque, Cedar Rapids, and Clinton. He was elected to the 96th Congress and is now serving on the Committee on Energy and Commerce, the Committee on Education and Labor, and the Select Committee on Aging.

Without objection, all of your prepared statements will appear in the record, and why don't you start off in the order I recognize you, and enlighten us in any manner you are comfortable.

STATEMENT OF HON. BYRON L. DORGAN, A REPRESENTATIVE IN THE 98TH CONGRESS FROM THE STATE OF NORTH DAKOTA

Mr. DORGAN. Mr. Chairman, thank you very much. I will make a couple of comments, turn it over to Mr. Synar, Mr. Tauke, and Mr. Slattery. Mr. Synar and Mr. Tauke are cochairs of the Rural Health Caucus. I have been chairing the task force on rural hospitals in that caucus.

Let me start by saying I don't think we have a lot of disagreement if we accept your offer made to Mr. Flippo, and I think without asking the other three, we do. The offer, I think, was that rural hospitals are paid what other hospitals are paid and that we eliminate the differential, then let the market forces determine which stay open and which don't.

That's an offer I think most of us accept. On Saturday afternoon I flew into an airport about 30 miles south of the Canadian border. There was an ambulance waiting next to the airstrip and I asked the ambulance driver why he was there. He told me that he was waiting for a doctor to fly in because a young Indian boy on the reservation had been run over by a lawnmower about an hour prior to that. It reminded me again of the extraordinary importance of health care in remote and rural areas.

It is harder for someone who lives in downtown Chicago to understand the need for health care if you have a 2-year-old boy that is run over by a lawnmower in the middle of the afternoon out in the country. My point is that we understand that we are not going to have a hospital every 3 miles and that we are not even going to keep all the current hospitals in rural America open forever. All of us understand that.

But we also understand, Mr. Chairman, that it exacerbates the problems of rural hospitals when we have a payment formula that says to rural hospitals, right from the start, you are going to get a whole lot less than other hospitals.

You said in your statement, Mr. Chairman, that the problems of rural hospitals won't be resolved by throwing money at them. It is true, it won't be resolved by throwing money at them, but the problems will be exacerbated by withholding money that they should have, and that's exactly what has happened to every rural hospital in America under the current Medicare reimbursement system.

Mr. Chairman, you and I sat on this committee when we approved that prospective payment plan. You and I both know that the promise that was made under that plan has not been kept. That promise was a single national rate for Medicare reimbursements to hospitals. I think the first thing that all of us say we need is to make sure that promise will be kept.

That promise will be kept by the offer you made with the first witness. Second, in light of what you indicated in your statement, Mr. Chairman, namely, that we don't want to get bogged down with a discussion about rural versus urban, I will say the following. Frankly, that is the ball game. Rural versus urban determines who gets what, and it determines under today's circumstances that rural hospitals get a whole lot less than everybody else.

Finally, Mr. Chairman, let me tell you that while we insist on working toward a system in which rural hospitals get fair compensation so that we don't preordain their death by a system that is unfair, all of us on this panel understand that some day there are going to be additional closures of rural hospitals that probably should not stay open. We are perfectly willing to work with you and others on a whole series of things, most notably, for example, a program that might develop the system of facilities that are much more than clinics, but slightly less than full service hospitals in areas that otherwise would currently lose their hospital.

We are willing to work on that and want to work on it with you. However, we have to start by solving the funding problem that preordains that rural hospitals are going to be siphoned dry of the ability to stay open because the payment system says you get a lot less and somebody else gets a lot more. All this despite the fact that when the PPS system was passed we were promised it was going to be even.

That is the message, and we look forward to working with you to address the many challenges facing rural hospitals. Now let me turn it over to Congressman Synar.

[The statement of Mr. Dorgan follows:]

TESTIMONY OF

THE HONORABLE BYRON L. DORGAN

BEFORE THE WAYS AND MEANS SUBCOMMITTEE ON HEALTH

MAY 15, 1989

Mr. Chairman, I appreciate the opportunity once again to address this Subcommittee on issues which mean a great deal to me: those relating to rural health care. This is the second time I have addressed this Subcommittee this year on rural health issues. My reappearance should clearly indicate my commitment to working with you and the Members of this Subcommittee to pass legislation that will substantially impact health care delivery in rural areas.

Earlier this year I introduced legislation designed to address many of the most pressing issues facing rural hospitals relating to Medicare reimbursement. HR 1583, the Rural Hospital Recovery Act of 1989, contains a number of provisions and proposals aimed at rectifying the inadequacies and inequities in Medicare reimbursement to rural hospitals. Just last week I introduced another bill which would establish demonstration projects, funded through the Rural Health Care Transition Grant Program, establishing "medical assistance facilities." A medical assistance facility would provide a viable alternative to full hospital service. In my testimony today I would like to address the essential priorities for what Congress must do this year if we are serious about addressing the challenges confronting the survival of rural health care. Mr. Chairman you can refer to my legislation for the specifics of my proposals on how to address these issues.

First, we must make a commitment to eliminate the urban/rural differential in the standardized rate, and stick to that commitment. Mr. Chairman, I sat with you on this Committee when we passed the Prospective Payment System, enacting different rates for urban and rural hospitals for the purpose of Medicare reimbursement. When we passed the PPS legislation, we were promised a signal standardized rate for all hospitals. We have yet to see that promise fulfilled.

In my legislation, I propose that we phase-out the differential over a three year period. We must begin the process of eliminating the differential this year. Different payment rates for various hospitals, based on an arbitrary geographical classification, must be replaced by a more sophisticated payment system that incorporates adjustments that reflect the differences in case-mix, severity of illness, and other factors into a single rate. The current differential is arbitrary and not justifiable.

I urge this Subcommittee to provide a higher update for rural hospitals as part of a commitment to work toward a signal national rate. According to the proposed rates for fiscal year 1990 published this week, the Health Care Financing Administration "strongly recommends" a higher update for rural hospitals.

Second, some form of transitional reimbursement program ought to be established that will provide immediate assistance to small rural hospitals that are financially very susceptible to closure. The fact is: the current PPS system does not work for small rural hospitals with low occupancy rates and a high dependency on Medicare patients. The Prospective Payment System is based on the assumption of the "law of large numbers." Rural hospitals, which typically have a high degree of dependency on Medicare patients, do not receive enough profits from other patients to make up for the losses they incur from Medicare patients.

[2]

In my legislation, I propose a reimbursement system that provides additional payments to guarantee a reimbursement at the reasonable cost level for small rural hospitals that serve a high number of Medicare patients. Perhaps there are alternative payment systems that we can develop. I am open to working with this Subcommittee to develop such mechanisms. Whatever we devise, it is imperative that we take action to provide immediate assistance to the small rural hospitals on the verge on closure.

Mr. Chairman I want to make it clear that I am not advocating that Medicare has to save every rural hospital. I recognize that some hospitals, urban as well as rural, should be allowed to close. What I am advocating is the development of a stabilization strategy that will curtail the rapid decline of rural hospitals while we develop long-term, permanent solutions to providing health care in rural areas. Whatever interim provisions we may devise, I do believe that it must be tied to a long-term strategy for providing essential health care services in rural areas in a viable fashion.

Third, develop permanent solutions that will ensure access to care in rural areas. The development of a long-term strategy for ensuring access to health care in rural areas should entail two aspects: (1) establish a "critical access facilities" program designed specifically to support rural hospitals that must stay open if we believe that rural Medicare residents are entitled to hospital services; and (2) develop a program to establish creative new kinds of health care facilities that are more than clinics and less than those hospitals that provide acute care services for long periods of time. Last week I introduced legislation that would establish a demonstration project to set up "medical assistance facilities" which would provide limited inpatient care and stabilization in order to be transferred to a full hospital.

The Department of Health and Human Services recently announced its intention to study the issues affecting the critical access concept. The Rural Hospital Recovery Act, HR 1583, proposes establishing this kind of a program. I think that this concept has great promise. The critical access facilities notion provides a link to the challenges facing inner-city hospitals. I am very interested in working with this Subcommittee to devise a critical access facilities program that will help keep essential hospitals open, in rural areas and in the inner-city. Although rural hospitals and inner-city hospitals exist in entirely different environments, they share similar difficulties linked to inadequate Medicare reimbursement.

The Sole Community Hospitals designation does not adequately address the critical access concept. Because of problems with the designation criteria and the payment formula, many hospitals that could qualify find that participation in the program will not benefit them. The Rural Hospital Recovery Act contains provisions to modify the Sole Community Hospitals program by updating the hospital specific portion of the payment formula and by liberalizing the eligibility criteria. But we still need to move forward with an entirely different program to designate critical access facilities.

The second aspect of the long-term strategy for rural health care is to develop entirely new kinds of health care facilities that reach to the future of rural health care delivery. In HR 2327, the Rural Medical Assistance Facilities Act of 1989, I have proposed that a demonstration project be established that would create 10 to 15 medical assistance facilities. Under my proposal, the Health Care Financing Administration would be intrinsically involved in setting up these facilities and would study them and establish recommendations on how we can develop a Medicare reimbursement policy to encourage the establishment of these facilities and adequately and fairly provide Medicare reimbursement.

[3]

Factors such as declining admissions, high fixed costs, inadequate Medicare payments and physician shortages are making it more and more difficult for some rural hospitals to stay open. Rather than trying to save them all, we should work to help some of these hospitals adapt to the changing character of health care in rural areas. Medical assistance facilities are short-stay, low-intensity health care facilities that provide ambulatory, emergency, outpatient, and limited inpatient care in rural areas. Unlike full hospitals which provide inpatient acute care for longer periods of time, medical assistance facilities provide inpatient care for a maximum of 96 hours and stabilization care for transfer to another facility.

Special circumstances make it difficult for some rural communities to keep their hospitals open. A medical assistance facility concept would provide rural communities with a viable alternative for health care services. In the long run, we will be creating viable and efficient facilities that will save Medicare money.

My intent in drafting this legislation was to provide for the maximum amount of flexibility for state and local communities to develop these medical assistance facilities. Also, we need to be willing to experiment with alternative payment methodologies for these new kinds of facilities so that we can prudently develop fair and equitable policy.

I propose to fund the rural medical assistance facility demonstration program by authorizing a portion of the Rural Health Care Transition Grant Program. I urge the Subcommittee to increase the authorizations for the Rural Health Care Transition Grant Program. Not only will this allow us to establish the rural medical assistance facilities demonstration program but it will provide assistance for many rural hospitals to make necessary improvements and alterations to their facilities so that they can provide health care more efficiently.

Fourth, it is imperative that the Rural Referral Center classification be extended. The Omnibus Budget Reconciliation Act (OBRA) provided for a grandfather clause that is set to expire this year. My contention is that if we allow this classification to expire, we will only have more rural hospitals that will be struggling for survival. In the Rural Hospital Recovery Act I propose that the classification be extended until the urban/rural differential is eliminated. I urge the Subcommittee to adopt this language in extending the classification of Rural Referral Centers.

Finally, we cannot adopt a policy relating to limiting capital-related expenses that is based on hospital occupancy rates. I support legislation to curb the rising costs of capital-related expenses to the Medicare program. However, I cannot support any policy that ties occupancy rates to capital reimbursement. This approach will unfairly shift large amounts of Medicare funds to large urban hospitals.

By relating capital reimbursement to occupancy rates you are going to strangle rural hospitals. Rural hospitals would not be able to do the planning that is necessary to make them efficient facilities. Further, I am afraid that such a policy will only redistribute Medicare funds from lower-cost facilities to larger high cost facilities. Mr. Chairman, I urge you to avoid establishing any policy relating to curbing capital expenditures that is tied to occupancy rates.

In conclusion, I believe that we are standing at a critical moment in regard to the fate of rural health care. The alarming rate of rural hospital closures in recent years signals that access to health care in rural areas is in jeopardy. Something must be done to rectify the inadequacies and inequities in Medicare reimbursement, provide immediate assistance to rural hospitals on the fringes, and establish long-term solutions that will guarantee access to health care in rural areas. Mr. Chairman I urge you to seriously consider my proposals and I look forward to working with you in developing a prudent, fair, and equitable policy that will ensure access to health care to Medicare beneficiaries in urban and rural areas alike.

**STATEMENT OF HON. MIKE SYNAR, A REPRESENTATIVE IN
CONGRESS FROM THE STATE OF OKLAHOMA**

Mr. SYNAR. Thank you, Byron. Pete, let me echo what Byron just said. We will take that deal you just offered Mr. Flipppo. We don't want 50 percent more, we don't want triple what you are giving urbans. You give us that deal and there are 600 hospitals that are on what are called the endangered list this year. Every rural hospital that cannot survive based upon that deal, I think all four of us say, bye-bye, but they want the deal that they at least came into equally.

Second, let me take issue with something you said off the cuff, I don't think you really meant it. Post offices and military bases aren't hospitals. You can close a post office. You can close a military base and rural America will survive. You close a hospital, pull a doctor out of town, that town is gone, for all practical purposes.

We are going to divide this up. Let me talk about the second question you asked. I think we have answered which ones to keep open. Let me define something I think we need to be critically aware of, and that is critical access. Presently, critical access, we define it as those areas in the country that have got to have something, and that we have to not find special means to do it, but we have to understand that we are going to have during this transition period of whatever we come up with between Ways and Means and Energy and Commerce hospitals that are going to fall through the cracks unless we define them differently because it does us no good to close them and try to reopen them 3 or 4 years later after the transition.

I would argue the criteria for access critical are three-fold. One, percentage of Medicare and low income patients; two, geographical isolation, and, three, the health status of the community. I would also argue that in exchange for critical access definition, these hospitals have to adapt and consider new ways to create new missions or adjust their missions to adapt to the needs of their communities.

They cannot survive the way they are presently applying the trade. Then finally, back to where we started, and that is that we need this level playing field so we will really and truly know which ones can't survive and that we should not, as you clearly state, throw money at them.

I will turn it over now to my co-chairman—

Chairman STARK. Before you leave that, do you have any ballpark numbers in terms of access or isolation? I mean, or is there some magic number? Obviously if you have a patient up a mountain, getting down a mountain 10 miles is pretty long, but if you have to travel on a super highway, I can probably get in my district to a hospital 30 miles away faster than any of us could get to George Washington University Hospital during rush hour. So with the issue of time and distance, is there a minimum time and distance that you use in your definition?

Mr. SYNAR. The new system study that has just been done tells us it is going from 50 to 35 miles.

Chairman STARK. What you are saying is anything less than 35 miles is not critical? I mean, that is not 100 miles?

Mr. SYNAR. Yes, I think in the strictest definition of geographic isolation, yes, but the other thing you have to ask, and I think Jim Slattery may use this as an example, so I won't steal it, a rural county that has three hospitals obviously that is not a critical access area.

Let me let them speak. Then we can come back. They may answer that question as they go on. Tom Tauke, the cochairman next.

[The statement of Mr. Synar follows:]

Statement of Congressman Mike Synar
before the
Subcommittee on Health
5-12-89

Twenty-five percent of the nation's population lives in rural areas. One-fourth of all rural residents are elderly. According to a Select Committee on Aging report, rural elderly are in poorer health than their urban counterparts, have lower incomes, and more difficulty in obtaining access to important health care services.

Experts tell us there are many reasons that health care in rural areas is inaccessible: manpower shortages, inequitable Medicare and Medicaid reimbursement rates, and poor rural economies that can't generate local revenue, to name just a few. The reasons really don't matter. The bottom line is that a health care system which can't provide access to affordable care to all of its citizens regardless of where they live is unacceptable.

Ensuring that rural communities have access to quality health care is more than just a health issue. Rural cities and towns are in a catch-22: without good health care systems new industry will not locate in rural areas, yet without new industry hospitals and physicians can't afford to remain open.

Rural communities aren't asking for a handout, but they do deserve more equal treatment. Medicare beneficiaries in rural areas pay the same premiums as their urban counterparts and are entitled to the same access to health care.

It may be "penny wise" to promote policies which encourage hospitals to operate more efficiently. But it is most certainly "pound foolish" to pursue those policies when a community is left without access to health care. Rural beneficiaries will have to obtain care somewhere. Increasingly that will mean in an urban area at potentially greater cost to the federal government.

Rural hospitals should be encouraged to consider ways to adapt their missions to meet the needs of the people they serve. The Congress has provided some support in the form of the rural transition grants. This effort should be continued and expanded. Rural hospitals need time to assess their strengths and weaknesses. They need technical assistance from the federal government to help them develop innovative plans which allow them to meet health care needs within the framework of today's health care systems.

This Subcommittee has been struggling with an enormous task over the last several years -- curbing Medicare spending. Since 1980 Medicare expenditures have risen from \$32.1 billion to an estimated \$94.9 billion in 1990. This year's task is no less daunting. The Subcommittee must find over \$2 billion in Medicare savings.

In making the policy changes necessary to find these savings I hope the Subcommittee will not sacrifice the long term health care interests of rural Americans for short term budget savings. Although the focus of our attention has been on the survivability of rural hospitals, our attention should really be on the people who use those facilities. We should adopt health care policies that promote access to affordable health care rural areas.

STATEMENT OF HON. THOMAS J. TAUKE, A REPRESENTATIVE IN
CONGRESS FROM THE STATE OF IOWA

Mr. TAUKE. Thank you, Mike. Mr. Chairman and members of the subcommittee, it is good to be here. First of all, Mr. Chairman, I think we have got to look at this issue not from the standpoint of institutions, but from the standpoint of medicare recipients.

Medicare recipients in Waukon, IA, have every bit as much right to receive health care as Medicare recipients in Cedar Rapids, IA. I suspect we all agree on that. The question is how do we provide decent care? In order to provide decent care you have to have a rural health infrastructure. Hospitals are a critically important part of that infrastructure. It is awfully difficult to recruit physicians if there is not a hospital nearby where they can practice.

It is very difficult to keep other health care professionals in a community or in an area if there is no hospital nearby. Hospitals in the current structure of health care delivery systems in most areas of the country serve as a center for home health, for specialty clinics, and in many cases for nursing home care.

They provide the center for hospice, for preventive health care programs and for emergency services. Now, I agree with you that we have some transitions to go through in the United States of America. We can't expect that every community is going to have a hospital, and some hospitals which currently exist probably aren't going to survive in the new world, but I say two things.

One, we ought to let the marketplace decide who survives and who doesn't, and second there has to be some kind of transition system to get from A to B so that these individuals who live in places like Waukon, IA, are served.

Now, when you get to that you have got to look at urban versus rural, and Mr. Chairman, let me just say to you, I have got some classic examples of the problems that arise that have nothing, absolutely nothing to do with patient census.

In Clinton, IA, for example, we have their two hospitals which have done all the things that you want them to do. There were two separate hospitals in a community of 35,000 that is 30 miles away from an urban area of over 400,000. What did they do? They consolidated. They became more efficient. But, how can they compete when they get 35 percent less for performing an appendectomy or a gall bladder surgery than the hospitals that are 30 miles away in that metropolitan area of 400,000?

There is no way that they can compete when they are getting 35 percent less and are in the same marketplace, hiring from the same pool of professionals and are in the same geographic area for other cost purposes. The wages are the same, the costs are the same, but somehow they are supposed to get by on 35 percent less?

It is impossible to say urban-rural differential doesn't mean anything in a situation like that. I guess our bottom line is, if you give a hospital like that a fair shake, we think that hospital will do okay. If it doesn't, that is its problem, but give it a fair shake. Let me point out that this urban-rural differential is just a proxy for lack of better measurements. We would like to work with you to come up with better measurements, like the severity of the cases or refinements of the area wage indexes, but meantime we are stuck

with a very unrefined method for determining reimbursement; namely, urban-rural, simply because we haven't found something better.

If we find something better we will endorse it whole-heartedly. Meanwhile, don't just stick us with an urban-rural differential which in many cases doesn't reflect at all the severity of cases or the nature of the hospital that is providing the services. The last point I think is that in getting to that transition we need some help.

In my own State of Iowa, I think if you look at the record you will see that virtually all of our rural hospitals have made transitions. They are offering different kinds of services. Most of them have joined with an urban center hospital in some kind of a network in order to work with them to provide outreach services to rural residents, but provide sophisticated services and basic services in the urban center.

That is what we want. But if we allow some of the institutions to go under without replacing them with that alternative service, then our medicare recipients are the ones who suffer. Our goal is not to preserve every hospital as a full-service acute care facility, but we want the Medicare patients to have decent services.

[The statement of Mr. Tauke follows:]

Testimony of the Honorable Thomas J. Teuke (R-Iowa)
Subcommittee On Health
of the U.S. House Ways and Means Committee
The Impact of the Prospective Payment System on Rural Hospitals
May 15, 1989

Mr. Chairman, I want to thank you personally and on behalf of my colleagues on the bipartisan House Rural Health Care Coalition not only for holding today's hearing, but also for the rural hospital provisions your Subcommittee incorporated in the 1987 Omnibus Budget Reconciliation Act. Today's hearing and these provisions both demonstrate your concern for rural Americans' access to community-based health care services.

The rural hospital is the key to the viability of the rural health care delivery system. Physicians and other health professionals are reluctant to locate and remain in areas without hospitals. Rural hospitals are often the base of support for home health services, outpatient specialty clinics, and nursing home care.

Rural hospitals across America are in peril. We are witnessing record rates of failure. At the current rate of more than 40 closures a year, we will lose well over 400 hospitals in the next ten years, and the Senate Aging Committee has estimated that over 600 could be lost.

The House Rural Health Care Coalition recognizes that the factors behind these closures are complex and are not solely the result of federal reimbursement policies.

(1) Rural economies have been deeply troubled, limiting the ability of local communities to support their hospitals.

(2) Rural Americans are 25 percent more likely to be uninsured than their urban counterparts. Medicaid covers forty percent of the urban poor but only 25 percent of the rural poor. Rural hospitals thus shoulder a substantial burden of uncompensated care.

(3) The elderly comprise a higher percentage of the rural population, making rural hospitals particularly dependent upon Medicare revenues. In many cases, Medicare patients may comprise 70 percent or more of a rural hospital's patients.

Given rural hospitals' high percentage of Medicare patients and dependence upon Medicare for operating revenues, they are particularly hard-hit by several aspects of the Prospective Payment System. Refinements in this system are absolutely required if rural hospitals providing vitally needed services to Medicare beneficiaries are to remain viable and if the rural health care delivery system is to remain strong.

The Coalition is proposing that the rural/urban differential be phased out and replaced by more sensitive measures of differences in hospitals' costs. Today, the difference in total reimbursement for the same services in rural versus urban hospitals stands at about 30 to 40 percent. While it may be less expensive to provide care in rural hospitals, it is not that much

less expensive.

The rural/urban differential is a very poor and inequitable measure of differences in hospitals' costs. For example, the historically lower costs of rural hospitals may reflect their treatment of less complex cases in the aggregate. But should they be paid 30 to 40 percent less for treating a case of pneumonia than an urban hospital?

The Prospective Payment System applies a single area wage index to all rural hospitals in a state, as opposed to the urban area wage indexes, which are specific to Standard Metropolitan areas. Thus, the chances of a particular rural hospital's actual labor cost experiences differing from the wage index's assumption is far greater. This makes the system particularly inequitable for rural hospitals located near urban areas and competing in the same labor markets.

The differential makes it very difficult for rural hospitals to compete for and retain nurses and allied health professionals. Urban hospitals can offer salaries and other benefits at levels substantially higher than rural hospitals, making it well worth a rural nurse's while to undertake lengthy commutes to work in an urban setting.

For these reasons, the Coalition would argue that eliminating the rural/urban differential and replacing it with more sensitive measures of hospital differences is sound policy and a matter of simple equity.

Recognizing that the development of these more precise measures of hospital differences will take some time and that many rural hospitals need more immediate relief to avert closure, the Coalition strongly urges a full inflation update for rural hospitals and an increased authorization for the rural hospital transition grant program. We also request that you consider our proposal to elevate the Office of Rural Health Care within the Department of Health and Human Services and provide funding for this office, which can provide valuable guidance to rural communities and hospitals on alternatives for ensuring continued access to basic health care services.

While eliminating the geographic differential is essential, other refinements in the Prospective Payment System are also needed to respond to the unique characteristics of rural hospitals.

The Prospective Payment System assumes that hospitals have the volume to balance losses on some cases against gains on others and to spread out losses over a volume of cases. Many rural hospitals, operating efficiently and providing much-needed care to their communities, do not have this volume. One or two high-cost

cases can plunge the hospital into severe financial difficulty. While we have made some improvements in outlier policies to provide protection against high-cost cases, the smallest rural hospital must incur the same threshold of loss as its urban counterparts before outlier payments are made. Again, the rural hospitals' high percent of Medicare patients and dependence upon Medicare for operating revenues also make losses on DRGs a substantial threat to a hospital's viability.

The Coalition is not advocating that Medicare subsidize every rural hospital. We recognize the fact that in many rural areas, we are overbedded and that not every rural community needs or can support a full-service hospital. Hospitals and communities need to consolidate services and change the mix of services, and the Coalition strongly supports the rural hospital transition grant program and other incentives to assist hospitals and communities to make these changes. In many of our communities, that process of change is well underway already.

The Coalition is advocating stronger protections for those hospitals which are the sole source of care for their communities. We recommend refinements in the current sole community hospital program to better determine which hospitals are essential to access to care either for an entire community or for a population within an area, such as the indigent, and additional payments as may be necessary to retain core services.

Twenty-five percent of this nation's population lives in rural areas. If we do not act now to refine the Prospective Payment System to reflect the unique characteristics and challenges of rural health care delivery and to identify and better protect rural hospitals which are essential to access to care, we will condemn rural Americans to the further deterioration of basic health care services and of the rural economy as a whole.

Ensuring that rural Americans have access to community-based care is not only sound health policy, it is sound fiscal policy as well. The wholesale closure of rural hospitals, which as a class provide care at less expense to Medicare, will force rural Medicare beneficiaries to urban centers, where care is more costly.

Again, thank you for this opportunity to present the House Rural Health Care Coalition's deep concern about and recommendations for the future of rural hospitals and the rural health care system. We appreciate your interest and courtesy in allowing us to testify today, and we look forward to working with you to develop specific proposals for your consideration.

Mr. SYNAR. Our next witness is Jim Slattery.

STATEMENT OF HON. JIM SLATTERY, A REPRESENTATIVE IN
CONGRESS FROM THE STATE OF KANSAS

Mr. SLATTERY. Thank you.

Mr. Chairman, it is good to see you. Thank you for holding this hearing. I appreciate it, and I think all of the people in the country that are concerned about the future of rural health care appreciate it. Let me just reiterate the point my colleague from Iowa just made.

I think a fundamental principle on which we base our argument, and that is the fact that people in rural areas who are eligible for Medicare are entitled to receive it. The fact is these citizens have paid the Medicare premiums just like citizens in Los Angeles or New York or Kansas City, for that matter, and they deserve the same benefits.

The next point I wanted to make today is that the prospective payment system is not working, and let's look at some of the basic information that we have, just basic facts that are available.

The prospective payment assessment commission [ProPAC] acknowledges that rural hospitals have fared poorly under the PPS system. They admit this. According to ProPAC, rural hospitals make up about 48 percent of all U.S. hospitals. They provide care for about 24 percent of Medicare patients in this country, but receive only 16 percent of all PPS payments.

In addition to that, I think it is important for us to look at how Medicare reimburse many of these rural hospitals. In Kansas all the rural hospitals on average realize a difference between Medicare cost and revenues of 17.5 percent.

In other words, those rural hospitals in Kansas that are attempting to do what we suggest, the beneficiaries of Medicare out there are entitled to, and that is to deliver this service, are not even being paid the cost of that service. They are losing money in the delivery of the service.

With regard to the suggestion that you made earlier about paying urban hospitals what—I mean rural hospitals what urban hospitals are paid, that is what we are here today to argue, and as far as I am concerned, there are a number of options that can be looked at, and the committee and the rural health care caucus looks forward to working together to try and figure out what makes some sense.

I would suggest to you that one of the things that can and should be done immediately is to allow the rural hospitals, and you can define the rural hospitals in a number of ways. I suggest you can say hospitals that are 60 beds or less, that maybe have a Medicare case load of a certain amount, 60 percent or 70 percent or more, and that have an average daily census of a certain number.

Those hospitals would be qualified to opt out from the PPS system if they are currently receiving significantly less than their urban counterparts. It seems to me that might be the quickest and easiest way to address this reimbursement differential, and it can be done, I would observe, for not a lot of money.

In fact, I introduced H.R. 1270. Let me point out this particular measure may not be endorsed by some of my colleagues, but this measure, according to the unofficial CPO cost estimate would cost only about \$50 million a year to finance. That is the one that would allow these hospitals to opt out from under the prospective payment system, and I would suggest that that is what we should do for a period of time, maybe 2 or 3 years, pending action by HCFA and ProPAC to determine really what can be done on the long term to address this problem consistent with some of the concerns that have been raised by my other colleagues and by you, Mr. Chairman, because I think we all recognize that the mission of some of these rural hospitals in the years ahead is going to have to change.

We understand that. But all we are suggesting is that these hospitals in the interim should be given the opportunity to compete with their urban counterparts, and if that is, in fact, what we do with Federal policy, then I think we have done what we must do to assure that health care is available all across this country in our rural areas as well as our urban areas.

And just in closing, and I anticipate questions from the Chair and other members of the committee, I would observe that all we are really basically talking about is fairness. Pay the rural hospitals at least a cost of delivering the health care that the Federal Government says they are entitled to and pay the providers at a rate equal to what their urban counterparts are getting, and I think that we will have done what we should be doing to deal with this problem.

So, Mr. Chairman, I will conclude my formal remarks and ask that our prepared statements be made a part of the record.

[The statement of Mr. Slattery follows:]

TESTIMONY OF THE HONORABLE JIM SLATTERY (2ND-KS)
BEFORE THE HOUSE WAYS AND MEANS
SUBCOMMITTEE ON HEALTH

MAY 15, 1989

MR. CHAIRMAN:

THANK YOU FOR PROVIDING MY COLLEAGUES AND ME THE OPPORTUNITY TO APPEAR BEFORE YOUR SUBCOMMITTEE TO TALK ABOUT OUR CONCERNS REGARDING MEDICARE REIMBURSEMENT AND RURAL HOSPITALS.

WHEN WE LOOK AT THE PROBLEMS FACING RURAL HOSPITALS TODAY, WE MUST DO SO IN THE CONTEXT OF LOOKING AT RURAL COMMUNITIES AS A WHOLE. RURAL HOSPITALS ARE MUCH MORE THAN A SOURCE OF HEALTH CARE IN RURAL COMMUNITIES.

THEY ARE OFTEN THE LARGEST EMPLOYERS IN THEIR COMMUNITIES AND THE KEY TO ATTRACTING AND RETAINING PHYSICIANS AND OTHER HEALTH CARE PROVIDERS. WHEN RURAL COMMUNITIES LOSE HOSPITALS, THEY LOSE NOT ONLY ACCESS TO ACUTE CARE, BUT NURSING CARE, HOME HEALTH CARE, PHYSICIAN CARE, JOBS, AND THE ABILITY TO ATTRACT NEW BUSINESSES AND INDUSTRIES.

DESPITE THE CRITICAL ROLE THAT RURAL HOSPITALS PLAY IN MAINTAINING THE QUALITY OF LIFE IN RURAL AMERICA, THE FUTURE OF MANY OF OUR RURAL HOSPITALS IS IN JEOPARDY.

ONE OF THE REASONS RURAL HOSPITALS ARE IN TROUBLE IS THE PROSPECTIVE PAYMENT SYSTEM (PPS). I DO NOT MAKE THIS STATEMENT LIGHTLY, BUT OFFER THE FOLLOWING FACTS TO SUPPORT THIS CONCLUSION.

THE FIRST FACT IS THAT THE PROSPECTIVE PAYMENT ASSESSMENT COMMISSION (PROPAC) ACKNOWLEDGES THAT RURAL HOSPITALS HAVE FARED POORLY UNDER PPS. ACCORDING TO PROPAC, RURAL HOSPITALS MAKE UP ABOUT 48 PERCENT OF ALL U.S. HOSPITALS; PROVIDE CARE FOR ABOUT 24 PERCENT OF THE MEDICARE PATIENTS; BUT, RECEIVE ONLY 16 PERCENT OF ALL PPS PAYMENTS. AN EXAMINATION OF THE DISTRIBUTION OF PPS OPERATING MARGINS SHOWS THAT TEN PERCENT OF RURAL HOSPITALS EXPERIENCED NEGATIVE MARGINS OF -34 PERCENT OR LOWER IN THE FOURTH YEAR OF PPS. TWENTY-SIX PERCENT OF RURAL HOSPITALS HAD NEGATIVE PPS MARGINS FOR THREE OR MORE YEARS OF PPS.

IN KANSAS ALL RURAL HOSPITALS ON AVERAGE REALIZE A DIFFERENCE BETWEEN MEDICARE COSTS AND REVENUES OF -17.5 PERCENT. BECAUSE THIS IS AN AVERAGE, IT STANDS THAT MANY RURAL HOSPITALS IN KANSAS REALIZE AN EVEN GREATER DISPARITY BETWEEN MEDICARE COSTS AND REVENUES. FOR EXAMPLE, THE EIGHT HOSPITALS WITH LESS THAN 50 BEDS IN MY DISTRICT HAVE AN AVERAGE MEDICARE MARGIN OF -36 PERCENT.

PPS ASSUMES THAT HOSPITALS HAVE THE VOLUME TO BALANCE LOSSES ON SOME CASES AGAINST GAINS ON OTHERS. THE LOW VOLUME CHARACTERISTIC OF RURAL HOSPITALS PLACES THEM AT A DISADVANTAGE. PPS DOESN'T WORK WHEN THE SIZE OF THE FACILITY IS TOO SMALL--THERE ARE SIMPLY NOT ENOUGH CASES TO ASSURE THAT FINANCIAL LOSSES ON SOME CAN BE MADE UP BY GAINS ON OTHERS. ONE OR TWO HIGH-COST CASES CAN SPELL DISASTER FOR RURAL HOSPITALS, PARTICULARLY GIVEN THE HIGH PERCENTAGE OF MEDICARE CASES THESE HOSPITALS TREAT.

CONTRIBUTING TO THIS PROBLEM IS THE FACT THAT RURAL HOSPITALS ARE PAID LESS THAN URBAN HOSPITALS UNDER PPS. THE DEPARTMENT OF HEALTH AND HUMAN SERVICES PPS REGULATIONS FOR FY 1989 SHOW THAT AVERAGE PPS PAYMENTS PER CASE FOR RURAL HOSPITALS ARE JUST 66 PERCENT OF THE NATIONAL AVERAGE, EVEN AFTER THE HIGHER UPDATES CONGRESS HAS PROVIDED. PPS PAYMENTS PER CASE FOR SMALL RURAL HOSPITALS AVERAGE JUST 56 PERCENT OF THE NATIONAL AVERAGE--AND LESS THAN HALF OF WHAT HOSPITALS IN LARGE URBAN AREAS ARE PAID. THIS DIFFERENTIAL IS PATENTLY UNFAIR AND MUST BE ELIMINATED.

IT IS INTERESTING THAT WHILE SMALL RURAL HOSPITALS HAVE STRUGGLED WITH THE INADEQUATE AND INEQUITABLE NATURE OF PPS, THEY HAVE BEEN HELD TO THE SAME STANDARDS OF CARE AS THEIR URBAN COUNTERPARTS. FOR THIS IDENTICAL CARE THEY ARE REIMBURSED AT A RATE WHICH VARIES FROM 25 TO 40 PERCENT LESS THAN URBAN HOSPITALS BY MEDICARE.

TODAY, AS PART OF ANOTHER PANEL FROM WHICH YOU WILL HEAR LATER, JOSEPH ENGELKEN, ADMINISTRATOR FOR ONAGA HOSPITAL IN MY DISTRICT, WILL TESTIFY THAT EVEN THOUGH HE HAS SUCCESSFULLY MAINTAINED HIS SMALL RURAL HOSPITAL AS A MODEL RURAL FACILITY--HE HAS DONE SO WITH NO THANKS TO MEDICARE. HE WILL CAUTION YOU AND EXPLAIN THAT HE CANNOT KEEP IT UP MUCH LONGER UNDER THE CURRENT MEDICARE REIMBURSEMENT SYSTEM.

MR. CHAIRMAN, WHAT CONCERNS ME IS THAT WHILE MANY RURAL HOSPITALS HAVE AVOIDED CLOSING, WE MAY BEGIN TO SEE THE DOWN-GRADING OF RURAL MEDICAL SERVICES AS THE SMALLER HOSPITALS SUCCUMB TO THE CURRENT FINANCIAL PRESSURES.

WHILE MEDICARE IS NOT RESPONSIBLE FOR SUBSIDIZING A DECLINING RURAL CENSUS, IT HAS A MORAL OBLIGATION, WHICH WE IN CONGRESS MUST ENFORCE, TO ASSURE EQUAL ACCESS TO QUALITY HEALTH CARE FOR RURAL BENEFICIARIES.

BENEFICIARIES IN RURAL AREAS PAY THE SAME PREMIUMS THAT URBAN BENEFICIARIES PAY. THEY DESERVE THE SAME BENEFITS.

I HAVE INTRODUCED LEGISLATION, H.R. 1270, WHICH WOULD PROVIDE SMALL RURAL HOSPITALS THE OPTION TO RETURN TO A REASONABLE COST-BASED SYSTEM UNDER MEDICARE. REP. DORGAN HAS INTRODUCED LEGISLATION, H.R. 1583, WHICH WOULD ALSO PROVIDE CERTAIN RURAL HOSPITALS THIS OPTION UNDER DIFFERENT CIRCUMSTANCES. AS YOU KNOW, SENATOR BENTSEN AND REP. PICKLE ALSO HAVE SIMILAR LEGISLATION, H.R. 762 AND S. 306.

THESE BILLS ATTEMPT TO ADDRESS SOME OF THE PROBLEMS SMALL RURAL HOSPITALS ARE FACING. BUT MORE IMPORTANTLY, THEY ADDRESS THE NEED AND RIGHT OF RURAL MEDICARE BENEFICIARIES TO HAVE ACCESS TO QUALITY HEALTH CARE.

MY BILL WOULD PROVIDE THIS OPTION TO RURAL HOSPITALS FOR AT LEAST THREE YEARS WHILE THE HEALTH CARE FINANCING ADMINISTRATION (HCFA) AND PROPAC DEVELOP RECOMMENDATIONS FOR AN ALTERNATIVE PAYMENT MECHANISM. WE NEED AN INTERIM PERIOD TO ALLOW SOME OF THESE HOSPITALS TO STABILIZE.

THE BOTTOM LINE IS THAT PPS DOESN'T WORK FOR RURAL HOSPITALS. WE NEED TO TEMPORARILY PROVIDE RURAL HOSPITALS WITH OPTIONS THAT WILL ALLOW THEM TO ASSESS THEIR FUTURE IN A STABLE ENVIRONMENT. LET'S PUT THEM ON A LEVEL PLAYING FIELD AND THEN SEE WHETHER THEY CAN HOLD THEIR OWN. LET'S NOT REFUSE THEM THE OPPORTUNITY TO SURVIVE BY NOT PLAYING FAIR.

WHAT ALL THESE BILLS DO IS PROVIDE OPTIONS--EACH BILL OR A VARIATION OF THEM WILL PROVIDE TEMPORARY RELIEF TO SOME HOSPITALS WHICH ARE IN TROUBLE. FRANKLY, I'M NOT SURE WHICH OPTION WILL WORK; BUT I'M HERE TO ASK THAT YOU PLEASE WORK WITH US TO FIGURE OUT WHAT WILL.

BECAUSE OF THE CONTINUING DIFFICULTY IN ADAPTING MEDICARE'S PPS METHODOLOGY TO THE UNIQUE CIRCUMSTANCES OF RURAL COMMUNITIES, I AM RECOMMENDING PROVIDING CERTAIN SMALL RURAL HOSPITALS THE OPTION TO REVERT BACK TO A REASONABLE COST-BASED SYSTEM FOR AN INTERIM PERIOD OF TIME. THIS WILL ALLOW FOR THE DEVELOPMENT OF LONG-RANGE SOLUTIONS TO FINANCE AND DELIVER ESSENTIAL HEALTH CARE SERVICES IN RURAL AMERICA.

THANK YOU.

Chairman STARK. Thank you. I want to thank the panel.

I hope you will be able to hear the inspector general review what the accurate facts relative to 1987 closings, are. This is necessitated by the fact that statistics are used often by lobbying groups to suggest to you that most hospitals in the country are closing, both urban and rural, charitable and everyone else unless we pay them more money. So you can understand why we get a little hardened to numbers here.

The fact that came up in the report of the 1987 closings is that there was virtually no difference between those urban hospitals and those rural hospitals that closed. Now it may have been on their impact to the community, but I am just talking about as you look at the institution, 37—

Mr. SYNAR. Mr. Chairman, that makes our argument that our rurals are being more efficient because if they are being reimbursed less as they were and still surviving while urbans are going down that are making more.

Chairman STARK. It might be, but it also reinforces, as you look at the numbers, that basically there were hospitals that were so small that they probably, regardless of what you pay them, can't survive in a modern medical climate. Now different people can take different views of that, but when you are taking occupancies averaging 9 and 10 patients, it is very difficult for a hospital under any circumstances to justify a variety of technical services when all that they have got is an average of 6 or 8 or 9 beds full.

They just can't provide all the variety of services that might be needed by a community. Now I just point that out as a question. What I haven't heard today is that—and this is a global problem, we have too many hospital beds in the United States.

The question is we never hear any testimony about how do we decide which beds ought to be put in moth balls. There are lots of reasons for that, because the practice of Medicare and medicine has changed, the PPS system has worked.

The problem is we haven't let it work. We haven't let hospitals close in cities or in rural communities where they should because the PPS system has, in fact, worked, but let me suggest to you a proposed solution, and let me see how you might react to this as a solution, and if you will be flexible on the number of miles which are easily changed, let me just outline a program. This would be, the first part of it would be to designate what we would call an essential access community hospital.

The program would go something like this: The hospitals would have to be more than 50 miles apart and more than 45 minutes traveling time. You can make that 30 minutes, 30 miles, whatever you want. Then you take all current rural referral centers that are existing now that they have been designated rural referral centers, which is a special designation, and you also take those less than 50 miles apart if they are not close to an essential access community hospital, a major hospital, so in other words, you can't just have an area where there is some 25-bed hospitals and each one is on a grade of 50 miles and there is still no major acute care delivery system necessary.

You also say that they have at least 75 beds, so you begin to say these are certain hospitals that look like they could survive in

terms of providing care in a modern high tech system. You then take the hospital that doesn't make the cut, and you convert them into a critical care program, and you give them the money so they can provide 24-hour emergency care. They would also hold beds for patients to be transferred, have agreements and transferring arrangements linked with one of the larger hospitals that would be in the grid, and they would provide for the interchange of records and be linked in a modern sense with transportation, records transfer and medical coverage with other centers.

Those hospitals you then take off the PPS system and say we will reimburse their costs, we guarantee they will stay. No new ones, but you take and you just put them into a classification. On an optional basis, if you want it, fine, they don't come into the system, but basically you take major centers that can be upgraded and get referrals from satellites.

You let certain satellites, giving them the capital to convert, and making them, in a sense, emergency care referral centers, and the ones who don't choose to join, take their chances. You convert to cost reimbursement for those. I would just appreciate any comments from the panel.

Mr. SLATTERY. Mr. Chairman—

Mr. TAUKE. Mr. Chairman, first it seems to me that we appreciate the thinking that goes into that kind of thing because I think it shows a real effort to try to deal with the problems that we confront in the rural areas.

Second, however, let me offer two observations. The first is that I don't know that it is necessary for us to do as much as you are suggesting in the sense that a lot of this is already occurring in rural areas, and many of the hospitals that you describe are doing very well, thank you, and they—I don't think we need to go so far as to take them off the PPS system or a system that is similar.

Chairman STARK. Then they wouldn't have to sign up for this plan.

Mr. TAUKE. No, but I am saying but why wouldn't they if they could get more money. I guess I am suggesting to you that that may be doing more than we actually need to do to have a decent health care delivery system.

I would frankly feel more comfortable if we would let the market decide which hospitals survive in my district rather than have that kind of system.

Chairman STARK. But where we already decided, Tom, I have nothing but complaints. Thirty-seven rural hospitals closed in 1987, and you would think it was the end of the world.

Mr. TAUKE. Let me just—I don't think you have heard what we have said. We are not saying that we should keep every rural hospital open, and I don't even argue that the rural hospitals in my State that have closed ought not to stay closed. What I am saying to you, Mr. Chairman, is—and this would be the second observation on your plan. I don't know how you justify the people in Clinton, IA, who have consolidated their hospital, how you tell them—two hospitals into one, how you tell them why they should get 35 percent less for a procedure than 30 miles away receives more.

Thirty-five percent more. How do you justify that to them? I don't know how you justify an urban differential. Put them on the

same reimbursement rate and the bad ones with the low patient levels aren't going to make it, you are right. So be it, but where they are innovative and moving into a system and making those changes you want to see made, they ought to have a chance to survive.

I think if you look at what is happening in my state or in some of the other states, that network of the urban center hospital reaching out to the rural hospitals, that is being milked right now. The problem is the one that we have been alluding to over and over again, we have two hospitals who are 35 miles apart, both are relatively decent hospitals, one gets 30, 35, 40 percent more for performing the exact same services the other one does. There is no justification.

Chairman STARK. That, I might say, happens in cities as well.

Mr. TAUKE. There is no justification there, either.

Chairman STARK. But it is a historic basis based on historic problems.

Mr. TAUKE. We promised when we established the prospective payment system, the whole promise was we would come up with a better method, a more sophisticated method for measuring severity of case, for looking at the case mix of hospitals and then coming up with a fair thing.

Chairman STARK. The other side was that we would let some hospitals close.

Mr. TAUKE. We say fine.

Chairman STARK. But they haven't. They haven't closed as rapidly—

Mr. DORGAN. Let me respond to that now. I have listened to you talk about the inspector general testimony later and others, and I think you are focusing on the wrong issue. I mean—

Chairman STARK. I know I am to you.

Mr. DORGAN. I think you are for you as well. Let me tell you why. Whether a hospital closes or not is not the issue for this panel. There are a lot of hospitals in North Dakota that can't close. They are seriously underfunded. Medicare affected them because the rate has not been established that was promised them, but the community can't allow the hospital to close.

The hospital loses more money than it should.

Chairman STARK. Why not?

Mr. DORGAN. Because the community is a remote community. The hospital is losing money. Medicare is not paying what it should pay, so the community has to make up the rest. They decide they are going to do that rather than let this place close despite the fact it is losing a lot of money.

What I am saying to you is, that is a community decision. But the amount of money necessary for those local areas to come up with to keep that hospital open is made much greater because we have decided in Congress to seriously underfund those facilities.

Now, I think Mr. Tauke and Mr. Synar and others would say: if you just give those facilities the same rate of reimbursement as other facilities, then perhaps the question of which to close and which not to close is more relevant. But it is not a very relevant criteria to have the inspector general tell us what has happened here, given the fact we have seriously underfunded rural hospitals

and forced many communities in my State—they are all nonprofit hospitals, incidentally—to come in and decide how to keep it open.

Part of the fundraising effort to make up those losses is to make up losses they shouldn't have had because they were underfunded by us. That is the point we are trying to make. If you will address that issue, I don't think you have to go quite as far as you have suggested. I think some of what you suggest here makes a lot of sense. I might say in my State as well, much of what is already going on feeds into this. By necessity, satellites and certain arrangements for air ambulances have been developed.

I think what you have said is constructive. However, I don't want you to dance on the head of that opinion on hospital closures forever because that is not the case we made. The case is adequate funding for those that still exist.

Mr. SLATTERY. Can I just follow up on this?

Chairman STARK. You are not alone. The problem with your theory is that we are also in many areas inadequately paying the inner-city hospitals in my district. So if I raise them to where they ought to be and they arguably have higher costs because they have a much broader array of services that they have to provide, much larger populations, and more high tech. Now if you begin to keep this PPS system up across the board, then present a more generous offer of 150 percent, and there just isn't enough money.

That is where we are on Mr. Slattery's budget dilemma.

Mr. DORGAN. I understand that, but let me say that when I sat over in that chair and you and I and the rest of the committee created this, it was not a theory. I don't view this as a theoretical question. It is the view of keeping the promise we made. The institutions we represent, those institutions will be well served if we keep the promise we made.

Chairman STARK. I don't think I was ever party to it.

Mr. SLATTERY. Mr. Chairman, I think it is important to realize this year the Medicare budget will increase between \$15 billion and \$16 billion, depending on who you listen to. The budget committee agreed to try to find \$2.3 billion in savings out of that increase. We need to find that to address this problem.

First of all, when you talk about this differential and the fact that the hospitals are being paid less, consider where we would be if many of these real hospitals close and the caseload was shifted to the urban hospitals.

If, according to the information we are all looking at, the urban hospitals are being reimbursed at a rate of 40 percent higher than the rural hospitals, the cost to the Federal budget would be significantly higher to deliver these services if those rural hospitals are forced to close. We need to keep that in mind.

Also, I would like to point out that when you raise this question, which we in the panel are sensitive to, which is the very legitimate concern to you, Mr. Chairman, about the future of our urban hospitals, especially those serving our inner cities, we know these hospitals are closing. I think it is important to know why they are closing. I would argue they are not closing because of Medicare reimbursement rate but because of cost shifting and unpaid for services they are providing.

When you look at the situation we are facing in rural areas, the problem these hospitals are dealing with is directly Medicare related. In my district, the eight hospitals I have in my district have a Medicare caseload ranging from a low of 45 percent to a high of 96 percent.

When you look at the Medicare profit margin among these hospitals, let me run over what it is. It ranges from a negative low of 20.5 percent, in other words, they are getting paid 20 percent less than the cost of the as far as, to a high of 55 percent. The average is 36 percent negative. I am talking in negative numbers.

I guess my point is, Mr. Chairman, that when you are looking at what is going on in rural America, it is important to realize that many of these hospitals are looking to Medicare for 35 to 70 percent, in some cases 80 percent, of their total funding. Why? Because they are delivering Medicare services.

When you talk about the inner-city hospitals, the problem is just as urgent, but the cause is entirely different.

Chairman STARK. I don't know if you have seen the CRS report on rural hospitals that just came out, but I will raise this to add a little contention here. The payment differential currently in effect, this is rural versus urban, are based on real numbers. They reflect differences in operating cost, and the wages paid by the hospitals in different areas and the relative costs of people with different diagnoses.

Nevertheless, the overall system is not as some critics have suggested based on unfounded presumptions about urban and rural costs. The rural costs did have lower average costs in the period. The most recent evidence available suggests that the difference between rural and urban costs have not changed significantly in the years since this study was implemented.

Mr. SLATTERY. We would all like to respond to that.

Chairman STARK. I am sure you would. I would suggest to you that there is some difference of opinion.

Mr. SLATTERY. Let me observe mathematically what happened. If you start in 1973 or 1975 and assume one procedure was going to cost \$1,000 if performed in an urban area and \$500 if performed in a rural area, and every subsequent year you applied it across the board, percentage increase, what you have done mathematically through that period of 15 years is exacerbate the original cost differential.

That is one of the things that is driving our frustration and brings us to the point today where we are suggesting this needs to be completely reformed. The original differential may have been partially justified, but it is not justified any longer compounded the way it is.

Mr. TAUKE. Mr. Chairman, you have also thrown all the hospitals in the State together to come up with a rural payment rate, so the 250-bed State in urban city is thrown in with the 20-bed hospital in the rural. It is unfair.

Chairman STARK. I wish you would argue with the guy who wrote this report. He contends quite the opposite. I am not sure that that will end the argument.

Mr. TAUKE. You indicated the inner-city problem. It is the same problem when you classify the inner cities. You have the same

problem as you do with rural. In rural, it is Medicare, and in rural it is Medicaid; but it is the same difficulty.

Mr. SLATTERY. Also, when you look at the costs the hospitals incur in Onaga, KS—and by the way, the administrator of that hospital is one of the most innovative and you will hear from him later today.

Chairman STARK. A 20-bed hospital with an average occupancy of seven.

Mr. SLATTERY. That is right. He will share with you a lot of creative things he has been able to do to keep that hospital afloat. You have to look at labor costs. Try and find a nurse to work in a remote rural area is often as expensive, if not more expensive to find a nurse in an urban center hospital.

Physicians are working for a hospital, and it doesn't cost less; in fact, I will argue you it costs more to get a good competent physician in a rural area than in an urban area.

Mr. DORGAN. Don't dismiss a 20-bed hospital with seven patients because if you live in a rural area, it is just as important to you.

Chairman STARK. Not if I can get into a big hospital in 20 minutes.

Mr. DORGAN. A lot of people in this country consider the small hospital very, very important. And in many cases, they cannot get to a big hospital in 20 minutes.

Mr. SLATTERY. This hospital with 20 beds with total average occupancy of seven is already doing many of the things you say should be done. It has a good referral arrangement with a nearby hospital. It is not doing major surgery.

I would make the observation that it is already doing a lot of things you suggest should be done in a search for a better delivery system.

Mr. SYNAR. Mr. Chairman, you give me equal reimbursement to urban area, nothing more, and I will let them fall where they may. That is all I ask, equal reimbursement. I am like Tauke. Just give us a level playing field, and if our hospitals cannot compete, fine, goodbye, and I will not come back here arguing or anything else.

Chairman STARK. Do you think they are all entitled to that?

Mr. SYNAR. Absolutely.

Chairman STARK. Why?

Mr. SYNAR. Because our people paid the same Medicare dollars in. Getting 35 percent less in Muskogee is intolerable. You cannot justify a 35 percent differential for 43 miles down the highway.

Chairman STARK. That is what our professionals are saying. They are suggesting that many of these differentials are in fact justified.

Mr. DORGAN. Mr. Chairman, I think we reached an area of agreement here, generally. This is a good place for us probably to conclude.

Let me make this point. We understand what you are saying. However, we have some areas of disagreement. I think there are some things all of us can do to work together to do things with respect to rural health care delivery. I hope in the coming weeks we can spend some time working on these concepts.

Mr. TAUKE. I think we do agree with the experts.

Chairman STARK. You have not heard from the rest of the committee.

Mr. TAUKE. We agree, but I don't think you will find an expert who says it should be based on geography but not on severity of caseload. We want to work with you to establish the differential for payment, but don't make it on a geographical basis. That doesn't make sense.

Chairman STARK. Mr. Gradison.

Mr. GRADISON. I represent a district with both rural and urban hospitals. That is why I have been so quiet. I am also painfully aware that this is a zero sum game. Most hospitals tell us they are hurting these days—not just rural and not just urban.

Anything we can do for one group means we can do less for others. That is the way the numbers work out. We have to do this with great care.

For example, in the testimony of our colleague, Mr. Flippo, he made a particular appeal and understandably so for hospitals which have particularly high Medicare loads. There are many non-rural hospitals that have heavy Medicare loads.

I was visited the other day by the representative of what to me is a new group of hospitals, representing 360 hospitals in this country, which have 65 percent or more of their patient days represented by Medicare. In other words, they don't have many places to cost shift.

The hospitals represented are not only rural but urban as well. They make the same point. Most hospitals tell us they are hurting. I think we have to do this carefully.

My sense of it is that in recent years, perhaps without sufficient speed, we have been trying to move in this direction. Two or three years ago, we took a step in this direction. I think we should continue. I hope you don't put us to the final test of doing the whole thing at once. I don't think that is going to be in the hearts of the other institutions.

Financial data on the condition of hospitals tend to lag. There is something to be said about the "steady as she goes" attitude. Let's try to get feedback as to the effects of our actions each year before we take another step.

Thank you.

Chairman STARK. Mr. Levin.

Mr. LEVIN. This group is as active as I thought it would be. I think it is useful to have four such articulate spokespeople arguing and talking with us.

Let me ask you about the level playing field. A level playing field is not necessarily a fair one if there are cost differentials. I don't—we should set the level—

Mr. SLATTERY. What Tom Tauke just said hits the nail on the head. If there is going to be a differential, base it on facts and considerations other than geography. I think that is what we are all basically saying here today.

Mr. LEVIN. Most of the differential relates to cost factors and caseload factors. They are not really geographic. They don't say so and so because it is rural and such and such because it is urban. It is the way these factors work out.

Mr. TAUKE. Mr. Levin, that is not true. In the State of Iowa, you have seven metropolitan areas. All the hospitals out of those areas are thrown into one basket and classified as rural, and their reimbursement is on that basis.

As I said earlier, if you have a hospital with 250 beds 35 miles away from a metropolitan area with 400,000 people and that hospital has a reimbursement rate 35-percent less even though they pay the nurses less, why is that? Because it happens to be in a city of 35,000, and it is called rural.

Mr. LEVIN. In that basis, it is geographical, but it is really the units we use considering these various factors. We worked with this 2 years ago. I think what you are saying is that the various factors today are not calculated in a fair way.

When you go down the differential and it is very significant, this is out of the CRS table, and it adds to a 67 percent difference urban and rural, and much of that relates to the wage index. That is 2 percent of it.

I think what you are saying is that we don't calculate that fairly. In that sense, it is geographical, but it doesn't have to be. We lump some areas together, but it is not supposed to be primarily geographical. It is the way we work it out.

If we used a different formula for a wage index, a more modern formula, it would still, in all likelihood be a different differential. It would be a different differential in the city of Detroit and the city of Cairo, MI.

Another part of that is the case mix index, which is not geographical. It has some relationship to geography and also the indirect costs of medical education, I suppose you call that geographical, but it really is not.

It just so happens if we are going to give any kind of bearing to graduate education, those centers are in urban or suburban areas. If you have a medical education in a rural area, it is paid for.

So I think what you said is a modification of the level playing field. What you are saying is you want a playing field that is on the level, not a level playing field.

Mr. TAUKE. If you have two hospitals that are the same size with the same case mix and are paying the same wages, they ought to get the same reimbursement, no matter where they are located. Today you have two cases, same wages and case mix, and they have dramatically different reimbursements because of geographical location.

Mr. LEVIN. So it means part of this is geographically driven, but a good part is not, except to the extent that the factors involved are out of date. I think we need to address it.

You probably are going to be tied up with other things, and you wouldn't be able to participate in the discussion with the inspector general.

I think most of the committee comes at this without a fixed position of rural versus urban. It seems to me that our basic premise does have to be unrelated to geography, except to the extent that geographical needs have some legitimate place.

For example, in isolated areas, I think geography is relevant. We have to have more than a level playing field. But what the chairman pointed out to you, what the inspector general's report shows

and this is for 1987, as you leave, I hope you will take this information and come back to us with your ideas, the occupancy rate of the rural hospitals closed in 1987 was 21 percent. That is the occupancy rate.

The average number—I think this was already discussed—the average patient census in those closed hospitals was nine people. Of those, four were Medicare patients. Of the 37 rural hospitals closed, or hospitals in 37 rural communities, in only 8 the residents have to travel more than 20 miles for emergency care.

Then in half of them, the former hospital building was converted to other health uses. So there is a problem.

While it is a bit adversarial here which helps to flush out the facts, I don't think any of us look upon this as adversarial. We don't want to adopt a formula that is empty of equity.

In my view, to simply say pay everybody the same does not have an equitable ring. True, they are all paid the same in Medicare, but we have not adopted that principle relating to Medicare.

Mr. DORGAN. Let me make this point. We adopted that very principle. That is the ~~equity~~ ^{equity} principle that drives the whole prospective payments system. The very principle is that in Illinois you had a hospital on this side of the city, and another hospital 40 miles away, and the same person with a heart attack paid \$2,000 more in one hospital than the other.

The whole purpose of prospective payment was let's pay them on DRG, and the more efficient will make money and the less efficient will lose it. That is the principle, nonetheless. I don't want any of us to misunderstand what prospective payment is about.

Mr. LEVIN. Except we built in a wage index, a nonlabor cost, which we did last time and I thought was justified. I thought it was very justified.

We also have a graduate medical education factor. So it is not correct to say we have a single factor except for rural areas.

Mr. DORGAN. Let me say again, because I don't think you were on the committee at the time, and I was here with Pete, what was built in represented in some instances a political makeup of committee, which represented urban interests versus rural. That is unfortunate, but I understand that.

That preordained the difficulty many small communities have to try to keep open many small facilities in their communities.

Mr. LEVIN. I am in favor of a system that is sensitive to the small community needs, but I don't think it is right to adopt a blind proposition that every place is paid the same, regardless of case mix, wage cost, regardless of whether they are performing other functions like medical education.

Mr. SLATTERY. One sort of closing comment by this member, and that is when you look at this wage issue, please keep in mind that it costs just as much, and I contend in the future, it is going to cost much more to get top quality health care providers to serve rural areas.

In my district in northeast Kansas, I know of health care providers who commute 50 or 60 miles one way to work in a rural hospital or doctor's office. I want you to keep that in mind.

I think there was an assumption in the past that somehow you could get nurses to serve in the small town hospital cheaper than in the Kansas City hospital. That is a wrong assumption.

There is a shortage of nurses, and if we are going to get the nurses to serve in a rural area, we will have to pay them as much or more than in the metropolitan area.

Many nurses in rural areas are going to be called upon in emergency situations to do a lot more than their counterparts will be asked to do in an emergency room in urban areas. We have to have the best we can buy.

Mr. SYNAR. Level playing field should be based not on geographical situations but cost of care. That is all we can.

Chairman STARK. Thank you all very much.

**STATEMENT OF RICHARD P. KUSSEROW, INSPECTOR GENERAL,
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**

Chairman STARK. Our next witness is the inspector general of the Department of Health and Human Services.

Mr. Inspector General, welcome back to the committee. Put on the blindfold of justice.

We have your report. It is obviously of some great interest. Would you proceed.

Mr. KUSSEROW. First, I am not a shrinking violet. On more than one occasion, I was tempted to leave the room and not provide testimony after the last discussion. Let me go ahead, and I will submit the total testimony for the record and highlight some positions of it, and I would also emphasize that I don't have a lot in the way of providing solutions to problems.

There is more of just describing what we have encountered. It is incumbent upon the Office of Inspector General as the watchdog for the beneficiary that we share the great concern the Congress is expressing over the need to have full access for all those entitled to health care benefits under these programs. We are definitely concerned and mindful of the promises made to the Nation's elderly and poor that they would have care available to them. With that in mind, I will go into the testimony relating to two facets of the access problem.

One is looking at the hospital closure issue, and the second is patient dumping. First on the hospital closure issue, I brought some charts here in which we illustrate some of the findings we have as we look at the 96 hospitals reported as closed in 1987.

This came about as a result of Secretary Sullivan, in his first hearing before the full Ways and Means Committee, being asked some questions about what was happening to rural hospitals. As a result of that, in March he asked me to begin a series of studies looking at the hospital closure issue and what effects it has had.

I will in the next month be issuing another report on profitability and financial condition of rural hospitals, trying to understand what were the factors of profitability and loss to the hospitals, in the hopes that it might present some insight on how to deal with this issue.

We are also doing a study on uncompensated care, and what effects that is having on the hospital industry. We are also looking at

hospital closures for 1987 and seeing what this snapshot tells us. We want to know if this is a trend that is growing.

We are looking at hospital closures in 1988.

We are also doing a study on hospital closure and its effects on quality care in the hopes we might be able to have some light on that side of the issue.

We are looking at access to hospital care when hospitals close and what beneficiaries are doing. Are beneficiaries having troubles finding care in the area?

Finally, we will be looking at the hospital viability and access to care in central cities. My current report is on general care hospitals and what happened in 1987. We examined the extent and characteristics of these hospitals, as well as the reason and impact of these closures, with particular emphasis on rural areas.

Of course, Mr. Chairman, we have made copies of the report available to the committee and will make as many other copies available as the committee may want.

We found that while some hospitals were closing the doors, the problem is not quite as severe as we originally thought. The hospitals that closed in 1987 were smaller in size and had lower patient occupancy rates, and most beneficiaries could get medical care nearby.

We found that 22 of the hospitals that had been originally reported as closed were not really acute care facilities and therefore did not enter into the equation.

We were concerned about the Medicare institutions that provided care for the elderly. We found included in the list psychiatric rehabilitation and other specialty hospitals that did not meet that definition.

In addition, we found 10 hospitals which had been reported as closed, actually closed in a year other than 1987. We found three were not closed but in fact were operating. We found eight not reported as closed, but which in fact closed in 1987.

So the final number was 69, not 96. Eight of these hospitals reopened in 1988. Thirty-two hospitals opened that same year with another 1,116 beds. Thus, one-third of the beds closed the end of the year had been restored.

The distribution of closed hospitals was divided fairly evenly between rural and urban: 37 in rural and 32 in urban areas. This is roughly proportional to their numbers nationally.

Among the characteristics of closed hospitals is that generally they were small. Almost two-thirds had fewer than 50 beds, and only 12 had more than 100 beds. The rural hospitals averaged 42 beds. The closed urban hospitals averaged 83 beds, which is just over one-third the 242-bed average for urban hospitals.

With regard to occupancy rates, which seemed to be the major factor, we found that occupancy rates for hospitals that closed were much lower than the national average: 21 percent versus 37 percent in the rural setting. Because of the small size and low occupancy rate of these hospitals, few patients were affected by the closures.

The average patient census of the closed rural hospital was 96, of which 4 were Medicare beneficiaries. We found that medical care was generally available at nearby hospitals for most patients dis-

placed. The major care was also available. All but 1 out of the 32 affected urban communities had care available within 10 miles.

In only one area was the traveltime over 30 minutes; Mullen, NE. That hospital had only nine beds and only 30 percent occupancy. Some hospitals had trouble meeting the health care standards. The Health Care Financing Administration had taken adverse action against 11 more of these hospitals for noncompliance with the standards in recent years.

We had another 11 hospitals that had been reported to our office for investigation of violation of the laws governing the program. Of that 11, 1 was cited for a civil monetary penalty. Three were recommended to the Department of Justice. Five of these investigations were closed, and one is pending.

That is a much higher average than before. Among factors that are causing closure, there is no single event that caused it. The occupancy declined. Costs continued to rise.

With regard to patient dumping, our concern was that those protected under title 18 of the Social Security Act should have access to necessary emergency care. Some for nonmedical reasons had been denied access for emergency medical treatment in hospital emergency rooms. We have had a shared responsibility for assuring people are not drummed out of the hospital.

The Health Care Financing Administration concern is primarily focused on making sure the hospitals are meeting that condition of participation, whereas our perspective is focused on past activities that would warrant action against the hospital for denying care as is provided for by law.

We also share a responsibility in this arena with the Office of Civil Rights which enforces the Hill-Burton antidumping provisions. Two-thirds of the hospitals that are subject to COBRA are also subject to the community service obligations under Hill-Burton. The difference between the two laws is that we have more teeth in our law and can take more aggressive action than the Office of Civil Rights, which has to undergo a protracted process before going to the Department of Justice.

We have two reports on the issue of patient dumping. I will submit those for the record. I will just mention the major findings.

We found—

Chairman STARK. Excuse me. Do you have any idea what one of the final regulations will be, or is that the next step?

Mr. KUSSEROW. I can answer that when I know when the final transition will be completed in this administration.

Chairman STARK. OK.

Mr. KUSSEROW. In our August 1988 report, we found that hospitals in our sample did not have records of transfer, so it was very difficult for us to determine whether or not they violated the antidumping provision.

We also found that hospitals and/or physicians persistently practice ways of subverting the intent of the COBRA provisions.

We found the procedures for investigating the referral dumping are new and evolving and not settled to a point of significance.

We found coordination in our Department had not had the priority it should. We also believe the resolution of dumping complaints

is time-consuming and probably not meeting the intent of Congress.

At the completion of these two reports, we have made significant progress both at the departmental level as well as the hospital level. A lot remains to be done, not the least of which is getting the regulations finalized. I hope we are in the 11th hour in that process, very close to the end.

In my formal testimony, Mr. Chairman, I have some basic recommendations that arise out of those reports. Much of it parallels the bill, H.R. 821, that has been introduced. Maybe I should stop now and use the remainder of my time for questions you and the committee might have.

Chairman STARK. I hope, too, that as your regulations come out, you will keep in mind the standing order you have from this committee, which is to provide us with any suggested legislation which will make it easier to enforce any of the regulations that you would like.

We are ready to be prompted on that end, and we look to you for direction on how the laws best help implement the intent of Congress. Don't be bashful. Let us know what we might do to make your life simpler or make your inspectors' work more effectively.

Mr. KUSSEROW. The last point, Mr. Chairman, was that a certain level of discomfort seems to be sweeping over us right now. That is that we rely upon the State survey and certification agency to a large extent to identify the problem and to determine through the audit, review, and survey process, whether or not there has been a violation.

The Health Care Financing Administration makes a determination when a hospital should be suspended or terminated from the Medicare Program. Once that has been resolved, then the case is referred to the inspector general, who looks to see if there are past sins that they were warned about, and then they are sent to the State licensing board.

We may go through a very protracted process where the Federal Government is assuming the burden to resolve the issue. It seems to me the principal responsibility for the protection of the health and welfare for the people in the States is in fact with the States themselves.

One of the things we suggested that maybe this committee and the Congress might want to explore is whether we can involve State licensing boards early in the process rather than have them sit on the sidelines, and whether we can give them at least the first opportunity to deal with the issue. Again, this goes back to the point that we are protecting people within the purview of our Federal authorities. But there are other people in the State which may not fall within the realm of that protection but who deserve not to be treated by certain physicians or hospitals that are providing substandard care. Along that line, we are taking on more and more responsibilities and relieving the States of a lot of responsibility that they maybe should have.

[The statement and attachment of Richard P. Kusserow follow:]

TESTIMONY OF RICHARD P. KUSSEROW
INSPECTOR GENERAL
DEPARTMENT OF HEALTH AND HUMAN SERVICES

GOOD AFTERNOON, I AM RICHARD P. KUSSEROW, INSPECTOR GENERAL OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES. WE APPRECIATE THE OPPORTUNITY TO SHARE WITH THIS SUBCOMMITTEE OUR OBSERVATIONS RELATING TO THE IMPORTANT QUESTION OF ACCESS TO HEALTH CARE-- ESPECIALLY AS IT RELATES TO INNER CITY AND RURAL HOSPITALS.

AS THE WATCHDOG OF THE DEPARTMENT'S PROGRAMS AND OPERATIONS, THE OFFICE OF INSPECTOR GENERAL (OIG) SHARES CONGRESS' CONCERN THAT THOSE IN NEED OF HEALTH CARE HAVE ACCESS TO IT. WE ARE CONCERNED TO ENSURE THAT THE PROMISE MADE TO THE NATION'S POOR AND ELDERLY THAT THERE WILL BE HOSPITAL CARE AVAILABLE TO THEM WHEN THEY NEED IT IS NOT AN EMPTY ONE BECAUSE ACCESS TO THAT CARE IS DENIED. ACCESS MAY BE DENIED IN A VARIETY OF WAYS: WHEN PHYSICIANS REFUSE TO CARE FOR HIGH RISK PATIENTS, WHEN HOSPITALS CLOSE THEIR DOORS, WHEN PATIENTS WITHOUT INSURANCE ARE TURNED AWAY FROM THE NATION'S HOSPITAL EMERGENCY ROOMS.

WE HAVE DONE WORK ON TWO ASPECTS OF THE ACCESS PROBLEM THAT WE BELIEVE WILL BE OF SPECIAL INTEREST TO THIS SUBCOMMITTEE: HOSPITAL CLOSURES AND PATIENT DUMPING. LET ME BEGIN WITH HOSPITAL CLOSURES.

HOSPITAL CLOSURES

THE AMERICAN HOSPITAL ASSOCIATION (AHA) REPORTED THAT 96 HOSPITALS CLOSED IN 1987, AND OTHER GROUPS RELEASED STUDIES PREDICTING SIGNIFICANT NUMBERS OF CLOSURES IN THE COMING DECADE.

BECAUSE OF THESE REPORTS AND CONCERNS EXPRESSED BY THE CONGRESS, PARTICULARLY DURING SECRETARY SULLIVAN'S APPEARANCE BEFORE THE FULL WAYS AND MEANS COMMITTEE IN MARCH, SECRETARY SULLIVAN ASKED US TO STUDY THIS PHENOMENON. WE WOULD LIKE TO SHARE THE RESULTS OF OUR STUDY, WHICH ARE FOUND IN REPORT WE ISSUED LAST WEEK.

OUR REPORT FOCUSES ON CLOSURES OF GENERAL, ACUTE CARE HOSPITALS IN 1987, THE LATEST YEAR FOR WHICH ACCURATE, DETAILED INFORMATION WAS AVAILABLE. WE EXAMINED THE EXTENT, CHARACTERISTICS OF, REASONS FOR AND IMPACT OF THESE CLOSURES, WITH PARTICULAR EMPHASIS ON RURAL AREAS. WITH YOUR PERMISSION, I WOULD LIKE TO OFFER A COPY OF THIS REPORT FOR INCLUSION IN THE RECORD.

WE FOUND THAT WHILE SOME HOSPITALS WERE CLOSING THEIR DOORS, THE PROBLEM WAS NOT AS SEVERE AS WE HAD ORIGINALLY THOUGHT. HOSPITALS THAT CLOSED IN 1987 WERE SMALL IN NUMBER AND SIZE AND MOST HAD LOW OCCUPANCY RATES. FEW PATIENTS WERE AFFECTED, AND MOST COULD GET MEDICAL CARE NEARBY.

WE FOUND THAT 22 OF THE HOSPITALS ON THE AMERICAN HOSPITAL ASSOCIATION'S (AHA) LIST OF 96 WERE NOT ACUTE CARE FACILITIES. INCLUDED IN THE LIST WERE PSYCHIATRIC, REHABILITATION, OR OTHER SPECIALTY HOSPITALS. IN ADDITION, 10 OF THE HOSPITALS REPORTED CLOSED HAD ACTUALLY CLOSED IN A YEAR OTHER THAN 1987, AND 3 WERE STILL OPERATING. WE ALSO DISCOVERED 8 CLOSURES NOT ON THE AHA LIST. THUS, ACTUAL NUMBER OF GENERAL, ACUTE CARE HOSPITALS THAT CLOSED IN 1987 WAS 69. HOWEVER, EVEN THIS MISSTATES THE PROBLEM, FOR 8 OF THESE HOSPITALS REOPENED IN 1988, AND 13 NEW HOSPITALS OPENED IN 1987.

THE DISTRIBUTION OF CLOSED HOSPITALS WAS DIVIDED FAIRLY EVENLY BETWEEN RURAL AND URBAN SETTINGS. THIRTY SEVEN OF THE CLOSED HOSPITALS WERE IN RURAL AREAS, 32 IN URBAN AREAS. THIS IS IN ROUGHLY EQUAL PROPORTION TO THEIR NUMBERS NATIONALLY.

CHARACTERISTICS OF CLOSED HOSPITALS

CLOSED HOSPITALS WERE SMALL. FORTY-THREE -- ALMOST TWO THIRDS -- HAD FEWER THAN 50 BEDS. ONLY 12 HAD MORE THAN 100 BEDS. CLOSED RURAL HOSPITALS AVERAGED 43 BEDS, ABOUT HALF THE 80 BED AVERAGE OF ALL RURAL HOSPITALS. CLOSED URBAN HOSPITALS AVERAGED 83 BEDS, JUST OVER ONE THIRD THE 242 BED AVERAGE OF ALL URBAN HOSPITALS.

OCCUPANCY RATES FOR HOSPITALS THAT CLOSED WERE MUCH LOWER THAN THE NATIONAL AVERAGE -- 21% VERSUS 37% FOR RURAL HOSPITALS, AND 30% VERSUS 56% FOR URBAN HOSPITALS. BECAUSE OF THE SMALL SIZE AND LOW OCCUPANCY RATES OF THESE HOSPITALS, FEW PATIENTS WERE AFFECTED BY THE CLOSURES. THE AVERAGE PATIENT CENSUS OF A CLOSED RURAL HOSPITAL WAS 9, OF WHICH ONLY 4 WERE MEDICARE PATIENTS. THE AVERAGE URBAN HOSPITAL CENSUS WAS 25, OF WHICH 10 WERE MEDICARE PATIENTS. WE FOUND THAT MEDICAL CARE WAS GENERALLY AVAILABLE IN OTHER NEARBY HOSPITALS.

EMERGENCY SERVICES WERE ALSO ACCESSIBLE TO MOST PEOPLE LIVING IN COMMUNITIES WHERE HOSPITALS CLOSED. ALL BUT ONE OF THE 32 AFFECTED URBAN COMMUNITIES HAD EMERGENCY CARE AVAILABLE WITHIN 10 MILES. ALTHOUGH DISTANCES WERE LARGER IN RURAL AREAS, GROUND OR AIR AMBULANCE SERVICES WERE AVAILABLE. IN ONLY ONE AREA WAS THE TRAVEL TIME OVER 30 MINUTES. IN THAT ONE CASE, IN MULLEN, NEBRASKA, THE HOSPITAL HAD ONLY NINE BEDS AND AN OCCUPANCY RATE OF 4%.

SOME CLOSED HOSPITALS HAD DIFFICULTY MEETING HEALTH CARE STANDARDS. FOR EXAMPLE, FIVE HAD BEEN INVOLUNTARILY REMOVED FROM THE MEDICARE PROGRAM FOR FAILURE TO MEET MEDICARE'S CONDITIONS OF PARTICIPATION. THE HEALTH CARE FINANCING ADMINISTRATION HAD TAKEN ADVERSE ACTIONS AGAINST 11 MORE FOR NONCOMPLIANCE WITH CONDITIONS OF PARTICIPATION IN RECENT YEARS.

FACTORS CAUSING CLOSURES

THERE WAS NO SINGLE FACTOR OR EVENT WHICH CAUSED HOSPITALS TO CLOSE. RATHER, A SET OF FACTORS RELATING TO HOSPITAL FINANCING GRADUALLY DIMINISHED HOSPITAL VIABILITY. AS OCCUPANCY DECLINED, REVENUES LAGGED, BUT COSTS CONTINUED TO RISE. OPERATING MARGINS SHRANK, AND ULTIMATELY THERE WAS NO CHOICE BUT TO SELL, MERGE WITH ANOTHER HOSPITAL, OR CLOSE THE DOOR. HOSPITALS THAT CLOSED WERE REPORTED TO HAVE HAD:

- DECLINING OCCUPANCY DUE TO LOSS OF REFERRING PHYSICIANS IN RURAL AREAS, PHYSICIAN REFERRALS TO MORE MODERN HOSPITALS NEARBY, PATIENTS CHOOSING LARGER HOSPITALS, MORE COMPETITION AMONG HOSPITALS GENERALLY, AND A SHIFT IN MEDICAL PRACTICE TO MORE OUTPATIENT CARE;
- DECLINING REVENUES DUE TO FEWER ADMISSIONS, LOWER THIRD-PARTY REIMBURSEMENT, AND MORE UNCOMPENSATED CARE; AND
- RISING COSTS DUE TO INCREASING DEMANDS FOR NEW MEDICAL TECHNOLOGY, SKILLED PERSONNEL, AND FACILITY MAINTENANCE, RENOVATION, OR REPLACEMENT.

DURING THE COURSE OF OUR STUDY WE NOTED THAT COMMUNITIES RESPONDED IN VARIOUS WAYS TO THE POSSIBILITY OF THEIR LOCAL HOSPITAL BEING CLOSED. SOME USED THE FACILITIES FOR OTHER MEDICAL CARE PURPOSES, SUCH AS LONG TERM CARE, CHEMICAL ABUSE TREATMENT, OR OUTPATIENT CLINICS. WE INTEND TO LOOK FURTHER INTO WHAT COMMUNITIES CAN DO IN THE FACE OF POSSIBLE HOSPITAL CLOSURE TO MAINTAIN ACCESS TO MEDICAL CARE.

PATIENT DUMPING

OUR CONCERN THAT THOSE PROTECTED UNDER TITLE XVIII OF THE SOCIAL SECURITY ACT SHOULD HAVE ACCESS TO NECESSARY HEALTH CARE EXTENDS TO THOSE WHO FOR NON-MEDICAL REASONS ARE DENIED ACCESS TO NECESSARY EMERGENCY MEDICAL TREATMENT IN THE HOSPITAL EMERGENCY ROOMS OF THIS NATION. I CERTAINLY DON'T NEED TO REITERATE TO THIS SUBCOMMITTEE CONCERNS ABOUT HOSPITALS DENYING EMERGENCY CARE TO INDIVIDUALS IN NEED OF IT INASMUCH AS THE ANTI-DUMPING PROVISION OF THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA) ORIGINATED HERE.

BACKGROUND

HOWEVER, BY WAY OF BRIEF BACKGROUND, THE STATUTE REQUIRES ALL MEDICARE PARTICIPATING HOSPITALS WITH EMERGENCY DEPARTMENTS TO EXAMINE ALL INDIVIDUALS REQUESTING ASSISTANCE. IF THE INDIVIDUAL IS IN ACTIVE LABOR OR HAS AN EMERGENCY MEDICAL CONDITION, THE HOSPITAL MUST PROVIDE STABILIZING TREATMENT. UNLESS THE PATIENT REQUESTS TRANSFER, AN UNSTABILIZED PATIENT MAY ONLY BE TRANSFERRED IF A PHYSICIAN CERTIFIES THAT THE MEDICAL BENEFITS OF TREATMENT AT ANOTHER FACILITY OUTWEIGH THE RISKS OF TRANSFER, AND THEN THE TRANSFER MUST BE CARRIED OUT UNDER THE CONDITIONS SPECIFIED IN THE STATUTE TO BE APPROPRIATE.

COBRA PROVIDED A NUMBER OF REMEDIES AGAINST A HOSPITAL OR RESPONSIBLE PHYSICIAN WHO VIOLATES THE ANTI-DUMPING PROVISIONS. CONGRESS CREATED A PRIVATE RIGHT OF ACTION FOR ANY INDIVIDUAL OR ANY RECEIVING FACILITY INJURED BY A VIOLATION OF THE STATUTE. IN ADDITION, THE STATUTE PROVIDES SANCTIONS THAT THE SECRETARY MAY APPLY. THE STATUTE SUBJECTS A HOSPITALS THAT KNOWINGLY OR WILLFULLY OR NEGLIGENTLY FAILS TO MEET ITS REQUIREMENTS TO TERMINATION OF ITS PROVIDER AGREEMENT, OR AT THE SECRETARY'S OPTION, SUSPENSION OF THE AGREEMENT FOR AN APPROPRIATE PERIOD OF TIME.

A HOSPITAL THAT KNOWINGLY VIOLATES A REQUIREMENT OF THIS SECTION IS ALSO SUBJECT TO A CIVIL MONEY PENALTY (CMP) OF UP TO \$50,000. FINALLY A RESPONSIBLE PHYSICIAN WITH RESPECT TO A HOSPITAL'S KNOWING VIOLATION, MAY HAVE TO PAY A CMP OF UP TO \$50,000 AND UNLESS THAT PHYSICIAN IS A SOLE COMMUNITY PHYSICIAN, MAY ALSO BE EXCLUDED FROM MEDICARE AND THE STATE HEALTH CARE PROGRAMS FOR UP TO FIVE YEARS.

HCFA AND OIG SHARE RESPONSIBILITIES

BOTH THE HEALTH CARE FINANCING ADMINISTRATION (HCFA) AND THE OFFICE OF INSPECTOR GENERAL (OIG) SHARE RESPONSIBILITIES UNDER THE STATUTE. EACH OPERATES FROM A SOMEWHAT DIFFERENT PERSPECTIVE. HCFA IS RESPONSIBLE FOR ENSURING COMPLIANCE WITH THE CONDITIONS OF PARTICIPATION, WHICH INCLUDES ENSURING THAT A VIOLATING HOSPITALS DOES NOT CONTINUE TO POSE A THREAT TO THE HEALTH AND SAFETY OF THOSE SEEKING EMERGENCY MEDICAL CARE. THE OIG GENERALLY FOCUSES ON EXACTING PENALTIES FOR PAST VIOLATIONS IN ORDER TO DETER FUTURE MISCONDUCT.

IF A COMPLAINT IS LODGED WITH THE DEPARTMENT, THE APPROPRIATE HCFA REGIONAL OFFICE ENSURES THAT IT IS PROMPTLY INVESTIGATED BY THE STATE SURVEY AND CERTIFICATION AGENCY. IF THAT AGENCY SUBSTANTIATES THAT THE HOSPITAL HAS EITHER KNOWINGLY AND WILLFULLY OR NEGLIGENTLY VIOLATED THE STATUTE, THE HCFA INITIATES AN ACTION TO TERMINATE THE HOSPITAL'S PROVIDER AGREEMENT. UNDER THE PROPOSED REGULATIONS, THE TERMINATION WOULD TAKE EFFECT WITHIN TWO DAYS OF THE HOSPITAL'S RECEIPT OF NOTICE UNLESS THE HOSPITAL CAN DEMONSTRATE THAT IT HAS POLICIES AND PROCEDURES IN PLACE THAT WILL ENSURE AGAINST FUTURE VIOLATIONS.

ONCE IT HAS ACTED TO ENSURE PRESENT PATIENT PROTECTION AND COMPLIANCE, THE HCFA REFERS THE CASE TO OIG FOR POSSIBLE IMPOSITION OF A CMP AGAINST THE HOSPITAL OR RESPONSIBLE PHYSICIANS WHO HAVE KNOWINGLY VIOLATED THE STATUTE.

OIG ENFORCES HILL-BURTON OBLIGATIONS

IT SHOULD ALSO BE NOTED TWO THIRDS OF THE HOSPITALS COVERED BY THE COBRA ANTI-DUMPING PROVISIONS, ARE ALSO SUBJECT TO THE COMMUNITY SERVICE OBLIGATIONS BECAUSE THEY RECEIVED GRANTS OR LOANS UNDER THE HILL-BURTON PROVISIONS OF THE PUBLIC HEALTH SERVICE ACT. A HILL-BURTON ASSISTED HOSPITAL IS PROHIBITED FROM DENYING EMERGENCY SERVICES TO ANY PERSON WHO RESIDES (OR, IF A TITLE XVI FACILITY, WORKS) IN ITS SERVICE AREA BECAUSE THE PERSONS CANNOT PAY FOR THE SERVICE. A HOSPITAL MAY DISCHARGE A PERSON WHO HAS RECEIVED EMERGENCY SERVICES OR IT MAY TRANSFER A PERSON TO ANOTHER FACILITY ABLE TO PROVIDE NECESSARY SERVICES -- BUT ONLY WHEN APPROPRIATE MEDICAL PERSONNEL DETERMINE THAT SUCH ACTION WILL NOT SUBJECT THE PERSON'S MEDICAL CONDITION TO A

SUBSTANTIAL RISK OF DETERIORATION. THE COMMUNITY SERVICE REQUIREMENT OF HILL-BURTON IS ENFORCED BY THE OFFICE OF CIVIL RIGHTS. HENCE, WHERE INVESTIGATION OF A COMPLAINT OF HOSPITAL DUMPING DISCLOSES THAT A HOSPITAL MAY HAVE VIOLATED ITS COMMUNITY SERVICE OBLIGATION, HCFA WILL ALSO REFER THE MATTER TO THE OFFICE OF CIVIL RIGHTS FOR APPROPRIATE REMEDIAL ACTION.

818 REPORTS

IN ORDER TO BETTER UNDERSTAND THE COMPLEXITY OF THIS ISSUE AND THE PROCEDURES ASSOCIATED WITH ENFORCING THE ANTI-DUMPING LAW, WE UNDERTOOK TWO STUDIES IN LATE 1988. WITH YOUR PERMISSION, I WILL SUBMIT THESE REPORTS FOR THE RECORD.

IN OUR AUGUST 1988 REPORT, WE ASSESSED THE MAGNITUDE OF THE DUMPING PROBLEM AND THE PERSPECTIVES OF HEALTH CARE PROFESSIONALS ON THIS ISSUE. WE FOUND THE FOLLOWING:

- HOSPITALS IN OUR SAMPLE DID NOT MAINTAIN RECORDS OF TRANSFERS. THEY COULD NOT UNIFORMLY OR CONSISTENTLY IDENTIFY PATIENTS THAT HAD BEEN TRANSFERRED INTO OR OUT OF THEIR EMERGENCY FACILITIES, AND EVEN WHEN PATIENTS COULD BE IDENTIFIED, THE INFORMATION ABOUT THEM WAS VERY LIMITED.
- HOSPITALS LACKED PROCEDURES FOR REPORTING DUMPING INCIDENTS. IN ADDITION, WHERE THERE WERE MECHANISMS, THE HOSPITAL WAS RELUCTANT TO USE THEM.
- HOSPITAL AND/OR PHYSICIANS PERSISTENTLY PRACTICED WAYS OF SUBVERTING THE INTENT OF THE CONRA PROVISION. SUCH PRACTICES INCLUDED DIVERTING PATIENTS DURING AMBULANCE TRANSPORT; REFERRING PATIENTS TO OTHER HOSPITALS WITHOUT RECORDING THAT THEY HAD REQUESTED TREATMENT FROM THE HOSPITAL; TRANSFERRING PATIENTS ELSEWHERE CITING THEIR INABILITY TO TREAT THEM WHEN IN FACT THE HOSPITAL WAS QUITE EQUIPPED TO CARE FOR THE EMERGENCY.

IN OUR NOVEMBER 1988 REPORT, WE LOOKED AT OURSELVES AND HOW WE WERE PROGRESSING IN IMPLEMENTING THIS PROVISION. WE FOUND:

- PROCEDURES FOR THE INVESTIGATION AND REFERRAL OF DUMPING COMPLAINTS WERE RELATIVELY NEW OR STILL EVOLVING.
- COORDINATION BETWEEN THE COMPONENTS HAD NOT BEEN A PRIORITY.
- RESOLUTION OF DUMPING COMPLAINTS IS TIME CONSUMING.

SINCE OUR REPORTS WERE ISSUED, SIGNIFICANT PROGRESS HAS BEEN MADE AT BOTH THE DEPARTMENTAL AS WELL AS THE HOSPITAL LEVEL. HOWEVER, MUCH REMAINS TO BE DONE. THUS FAR, WE HAVE SETTLED 7 CMP CASES OF PATIENT DUMPING. THIS HAS RESULTED IN A QUARTER OF A MILLION DOLLARS IN CMP'S. THE FIRST CMP CASE HAS BEEN TRIED AGAINST A RESPONSIBLE PHYSICIAN. ADMINISTRATIVE HEARINGS IN THIS TYPE OF CASE CONSUME THE SAME RESOURCES AS A TRIAL FOR MEDICAL MALPRACTICE. HOWEVER, WE HAVE FOUND THEM MORE ONEROUS THAN A MALPRACTICE TRIAL BECAUSE THE GOVERNMENT IS REQUIRED TO DEMONSTRATE A "KNOWING" BREACH OF THE PHYSICIAN'S OR HOSPITAL'S STATUTORY DUTY.

RECOMMENDATIONS

AS A RESULT OF OUR EXPERIENCE, WE HAVE A NUMBER OF SUBSTANTIVE AND PROCEDURAL RECOMMENDATIONS THAT WOULD IMPROVE THE ANTI-DUMPING PROVISIONS. SOME OF THEM ARE BEING IMPLEMENTED ADMINISTRATIVELY. OTHERS WOULD REQUIRE LEGISLATION.

1. KNOWING IS AN INAPPROPRIATE STANDARD

IT IS INAPPROPRIATE TO REQUIRE US TO DEMONSTRATE THAT A HOSPITAL OR PHYSICIAN KNOWINGLY VIOLATED THE STATUTE IN ORDER TO LEVY A CIVIL MONEY PENALTY FOR DUMPING. THE STATUTE IMPOSES AFFIRMATIVE DUTIES ON HOSPITALS AND, THROUGH THEM, ON PHYSICIANS TO EXAMINE, TREAT, STABILIZE, AND APPROPRIATELY TRANSFER INDIVIDUALS. FAILURE TO PERFORM THESE STATUTORY OBLIGATIONS ALONE SHOULD RESULT IN IMPOSITION OF A PENALTY.

WE BELIEVE THAT A CERTAIN PENALTY FOR THE VIOLATION OF THE STATUTORY DUTIES IS ESSENTIAL TO ADEQUATE DETERRENCE. THE TREAT OF TERMINATION MAY BE SUFFICIENT TO OBTAIN FUTURE COMPLIANCE. HOWEVER, A HOSPITAL RARELY SUFFERS ANY ACTUAL LOSS OF INCOME AS A RESULT OF A VIOLATION. HOSPITALS AND PHYSICIANS ARE MORE LIKELY TO OBEY THE STATUTE IF THEY KNOW THAT THEY WILL FACE SOME FINANCIAL DETERRENT IF THEY VIOLATE THE LAW AS OPPOSED TO A MERE WARNING RESOLVED BY A PROMISE OF FUTURE COMPLIANCE. HENCE, WE BELIEVE THAT REQUIRING THE OIG TO PROVE THAT A VIOLATION WAS A KNOWING ONE SETS TOO HIGH A STANDARD FOR THE FAILURE TO PERFORM DUTIES THAT THE STATUTE REQUIRES FOR MONETARY PENALTIES.

2. STAFF PHYSICIANS SHOULD BE RESPONSIBLE

WE ARE ALSO CONVINCED THAT THE TERM "RESPONSIBLE PHYSICIAN" IS TOO NARROWLY DEFINED TO FULFILL THE STATUTE'S FUNCTION OF SECURING EMERGENCY ASSISTANCE FROM ALL HOSPITALS WITH EMERGENCY DEPARTMENTS. CONGRESS CLEARLY ANTICIPATED THAT PHYSICIANS WOULD PERFORM ANY, IF NOT ALL, OF THE DUTIES THE STATUTE IMPOSES ON THE HOSPITAL TO EXAMINE, TREAT, STABILIZE, AND TRANSFER APPROPRIATELY. YET, UNDER THE EXISTING STATUTE, WHETHER A PHYSICIAN IS LIABLE FOR VIOLATING THE STATUTE TURNS ON THE NATURE OF HIS RELATIONSHIP WITH THE HOSPITAL.

ONLY A PHYSICIAN EMPLOYED BY OR UNDER CONTRACT WITH THE HOSPITAL WHO VIOLATES THE STATUTE AS AN EMPLOYEE OF THE HOSPITAL OR UNDER THE CONTRACT WITH THE HOSPITAL IS SUBJECT TO A PENALTY. THE STATUTE LEAVES OPEN FOR INTERPRETATION THE QUESTION OF WHETHER A PHYSICIAN WHO IS RESPONSIBLE FOR CARING FOR EMERGENCY PATIENTS AS A CONDITION OF ENJOYING STAFF PRIVILEGES IS UNDER CONTRACT WITH A HOSPITAL. THE OIG BELIEVES THAT A STAFF PHYSICIAN IS UNDER CONTRACT WITHIN THE MEANING OF THE STATUTE, AND THE PROPOSED REGULATION REFLECTS THAT INTERPRETATION. THE LAW SHOULD ELIMINATE ANY AMBIGUITY ON THIS POINT.

3. USE OF STATE LICENSING BOARDS

FINALLY, ALLOW ME TO SUGGEST POSSIBLE AREAS OF FURTHER EXPLORATION BY THE CONGRESS. DUMPING CASES ARE INITIALLY INVESTIGATED BY THE STATE SURVEY AND CERTIFICATION AGENCIES, WHICH DETERMINE NON-COMPLIANCE. THEY THEN TURN THE MATTER OVER TO THE FEDERAL GOVERNMENT, WHICH GOES THROUGH A PROTRACTED DUE PROCESS EFFORT. AT THE CONCLUSION OF THAT PROCESS, WHEN A PHYSICIAN HAS BEEN FOUND TO BE OUT OF COMPLIANCE BY ENDANGERING PATIENTS, WE REFER THE MATTER BACK TO THE STATE LICENSING BOARD.

IN INSTANCES WHERE IT APPEARS THAT A PHYSICIAN HAS VIOLATED THE STATUTE, THUS ENDANGERING PATIENTS, THE STATE MEDICAL LICENSURE BOARD SHOULD BE INVOLVED AT THE BEGINNING OF THE PROCESS, NOT THE END. CONGRESS MIGHT WISH TO CONSIDER GIVING A STATE MEDICAL LICENSING BOARD FIRST OPPORTUNITY TO ADDRESS THE PROBLEM. IF A STATE BOARD FAILED TO ASSUME RESPONSIBILITY FOR TAKING ACTION WITHIN SAY 30 DAY, THE OIG WOULD PROCEED TO DETERMINE WHETHER A PENALTY WAS WARRANTED. SHOULD THE STATE BOARD TAKE ACTION IT WOULD BE TO PROTECT ALL PATIENTS OF THE STATE AND NOT JUST THOSE COVERED BY THE ANTI-DUMPING STATUTE.

AS I NOTED, THE INVESTIGATION, PREPARATION, AND PROSECUTION OF

CASES UNDER THIS STATUTE IS A RESOURCE-INTENSIVE AS A MALPRACTICE ACTION, AND STATE LICENSING BOARDS ARE BETTER EQUIPPED TO ADJUDICATE THE QUALITY OF CARE ISSUES THAT THESE CASES POSE. MOREOVER, ORGANIZED MEDICINE HAS BEEN VERY VOCAL IN DEMANDING THAT PEER REVIEW BE ACCORDED PHYSICIANS AT THE OUTSET OF ANY INVESTIGATION OF PATIENT DUMPING ALLEGATIONS. INVOLVING THE STATE MEDICAL LICENSURE BOARDS EARLY IN THE PROCESS WOULD ENSURE THAT PHYSICIANS WERE JUDGED BY THEIR PEERS.

THIS CONCLUDES MY PREPARED TESTIMONY. I SHALL BE HAPPY TO ANSWER ANY QUESTIONS YOU MAY HAVE.

[THE REPORTS, "PATIENT DUMPING AFTER COBRA: ASSESSING THE INCIDENCE AND THE PERSPECTIVES OF HEALTH CARE PROFESSIONALS," AND "PATIENT DUMPING AFTER COBRA: U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES RESPONSE TO COMPLAINTS," ARE BEING RETAINED IN THE COMMITTEE FILES.]

DUMPING

Dumping the Poor

Despite Federal Law,
Hospitals Still Reject
Sick Who Can't Pay

Acutely Ill Are Transferred,
Turned Away at the Door;
Closed Emergency Rooms

Perils the Underinsured Face

By CLARE ANDREWS
Staff Reporter of THE WALL STREET JOURNAL
Since August 1986, it has been clearly illegal for hospitals to dump the poor. But that didn't save Terry Takesell.
Just a month after the federal law took effect, the 21-year-old diabetic became acutely ill. His neighbors in a small trailer park in Knoxville, Tenn., found the young man pale and distressed with sweat from a fever. An ambulance sped him to nearby Methodist Hospital, where the on-duty emergency room already had an outstanding bill of \$5,000. A director in the emergency room told staff members to alert hospital supervisors if Mr. Takesell ever returned.

He was in a hospital bed when an ambulance arrived. After speaking to Mr. Takesell briefly, the ambulance driver helped him to his feet and escorted him to the parking lot. Neighbors found him there under a tree and took him home; he died about 12 hours later.

Zellie May Holt testified at a congressional hearing last year that she is still torn, wondering whether Mr. Takesell would be alive today if she and other neighbors had moved him to another hospital. "We didn't believe the hospital would just let a person die like that for lack of money," she said.

The Hospital's Account

For its part, the hospital contradicted that Mr. Takesell left at his own accord. Instead, it said, the hospital was advised of any wrongdoing. But that finding outraged at least one attorney, Gordon Brownson of Legal Services of Maine Township. "You couldn't find a more indefensible case, yet nothing was done," he says. "That gives you an idea of how effective the law is."

Each year, despite statutes against the practice, hospitals dump—by transfer of economic, not medical, reasons—an estimated 250,000 people. Neither anti-dumping laws—federal, state and local—nor the nation's health care system's free emergency market pressure to shut many of the estimated 8 million Americans who have no health insurance coverage.

Increasingly, they are portents, rejected by a system determined to contain medical costs. And while hospitals talk about aiding the sick poor—and many, in fact, do—few welcome the responsibility. Nor do doctors, insurers, employers or Congress.

That helps explain a Chattanooga, Tenn., hospital dispatcher who told an ambulance crew not to bring in an unconscious man found in a poor neighborhood—because, he said, the administrator "would kill us if we took another indigent."

No Obligation to Pay

Richard Kirsch, the president of the American College of Emergency Physicians, says, "On the one hand, we have a moral, ethical and legal obligation to care a patient. However, on the other hand, we have a moral or legal obligation to pay for that care."

The theory here came up in the recent presidential campaign. Gov. Michael Dukakis said he wanted employers to provide minimum health insurance benefits, while Vice President George Bush opposed the idea on the ground that it would increase the cost of doing business and thwart job growth.

Still, a growing number of authorities agree something must be done. The newly elected National Academy of Sciences Institute of Medicine contends in a recent study that health care to the indigent is as critical as the AIDS crisis.

In the past, hospitals proved the costs of charity care—aid to patients covered by insurance. But now insurers have established limits and will pay only so much for any given hospital procedure. Insurance payments are staggered with Medicaid and Medicare payments, too. Fewer than two of five poor Americans are covered by Medicaid today, down from 67% a decade ago. California has dropped 250,000 of the working poor from its Medicaid program.

Absorbing the Cost

Unable to weather the cuts, more and more cash-poor hospitals are closing, leaving a smaller pool of mostly public and nonprofit hospitals to absorb the annual \$1 billion cost of uncompensated care. Joseph Deane, an insurance official at the Ohio State University Hospital, says he is seeing letters of protest to more than 15 Ohio hospitals that have transferred indigent patients to other hospitals. He wants them to "do their fair share."

Health industry officials say that laying the blame for dumping the poor isn't all that easy. "You can't just say these hospitals are dumping people and are morally deficient," says J.R. Silvers, a management professor at Case Western Reserve University's Health Systems Management Center. "Facing deficits, they must ask: 'Do you squeeze on the commercial side where people pay, or do you squeeze on the social side?'"

The health care system is more often choosing the latter course, and anti-dumping is the most graphic consequence. Some 15 million Americans are either denied care or don't seek it because they can't afford it, according to a study by the Robert Wood Johnson Foundation. And the

Please Turn to Page A11, Column 1

Wall Street Journal

Tuesday, November 29, 1988

Page A1

Dumping the Poor: Hospitals Shun The Sick Who Can't Pay the Bills

Continued From First Page

numbers are growing each year, the research group reports.

If hospitals don't frankly turn away the uninsured, they still sometimes close their emergency rooms, refuse Medicaid patients, or require payment in advance. "They may lock their doors on the side of the street facing a poor neighborhood," says Mr. Silvers. "It's not actual dumping, but it's the same thing—denying access."

Shunning Serious Illnesses

In Tennessee, Arthur Kellermann, who leads emergency services at Memphis's Regional Medical Center, says the human cost in pain and suffering is all too frequently ignored in the push to contain medical costs. "We aren't talking about a patient with no money who wants a lumpy tick or a face lift. We are talking about heart attacks and strokes and strokes and gastrointestinal bleeding."

The major push against dumping came two years ago when Congress passed the EMTALA law. Hospitals doing business with Medicare must treat patients with emergency conditions and all women in active labor, regardless of their ability to pay.

But although the law was passed for acknowledging that problem exist, it has also been criticized as largely ineffective. Enforcement regulations have yet to be adopted. Moreover, the law's terms are confusing. For example, patients must be "stabilized" before being transferred. But, says Judith Waxman, an attorney with the National Health Law Project, "the doctor's stabilized is another doctor's jump."

Last year in St. Louis, a young uninsured woman, five months pregnant, arrived at a hospital complaining of stomach pains. She was about to be transferred when she gave birth. The baby was stillborn. The hospital proceeded to transfer the woman—dead baby, medical cost and all. In Chicago, patients considered to be "stable" and thus transferable included a gunshot victim bleeding profusely from an artery to the brain and a man who had fallen from a third-story window.

In the Dark

If most Americans don't even know that an anti-dumping law exists, perhaps it is because no one is required to tell them about it. Even those doctors and hospitals receiving the dumped patients are reluctant to repeat violations or to move to stop them for fear of losing their relationship with other institutions.

Those who do often are misinformed. Ron Anderson, president and chief executive of Dallas's Parkland Memorial Hospital, says he was warned by peers that he would never find another job in hospital administration in Texas after he advocated a state anti-dumping law. And Dr. David Ansell of Chicago's Cook County Hospital says his own hospital held a press conference to rebut his study showing a threefold increase in dumping there.

Ignorance of the law is not evident reluctance to report violations help explain why the federal Health Care Financing Administration has found only 41 hospitals among several thousand in the U.S. to have violated the 1986 law. Just two hospitals have been booted out of the Medicare program as a result. Even so, says Mr. Thompson, says the problem is more pervasive than it seems. Federal authorities, he says, rely on politically sensitive state bonds in rule on complaints. The Takewell case, for instance, was considered by a state licensing board dominated by representatives of hospitals.

"There is a built-in conflict of interest that absolutely undermines the enforcement of the law," he claims.

The Inexplicably Underinsured

While dumping is most closely associated with the uninsured, the country's 50 million underinsured are at risk as well. Consider 61-year-old Mary Marshall, whose symptoms—a 101.8 degree fever, dehydration and hallucinations—caused her family to seek hospitalization. A private Tennessee hospital was prepared to admit her—then it, until it discovered she didn't have group insurance and her own policy provided inadequate coverage. She was told she needed to pay \$1,200 out of pocket and was sent home when she couldn't come up with the money. Later, her family took her to a local public hospital, and she was admitted there.

"The private hospital treated her like she didn't have any insurance at all," says Mrs. Marshall's daughter Judy Wilkerson. "If you don't have money, you're nothing."

A few states—notably Texas and California—have attacked the dumping problem with their own strict laws and vigorous enforcement. The Texas state attorney general's office is suing Humana Hospital Corp. in Harris County State District Court. The complaint alleges that Humana's Clear Lake Hospital dumped Mary Bourke, a 41-year-old housewife. Mrs. Bourke was admitted to the institution for a prescription-drug overdose and then was transferred to a public hospital—against the advice of the receiving doctor—because she had no insurance. While she was in transit, Mrs. Bourke's heart stopped. Resuscitated, she became comatose. She died without regaining consciousness. A Humana spokesman says he can't discuss details of the matter because it is in litigation but adds, "Certainly, we are defending the case."

Now, 'Reverse Dumping'

Cases such as Mrs. Bourke's are declining in Texas, and officials there credit the state's anti-dumping law. But now they are observing a new phenomenon: "reverse dumping," in which larger hospitals refuse to accept uninsured patients from smaller, less sophisticated ones.

Kevin Morris, the administrator of tiny Culberson County Hospital, which is situated on a desolate stretch of flat Texas highway, spent four hours begging hospitals to take a late an indigent man whose leg had been all but amputated by a train. Because the small hospital lacks surgical facilities, doctors there couldn't even finish the job of cutting off the leg. "We just tried to make him comfortable until we finally found someone to take him," says Mr. Morris.

In another remote Texas town, a 17-year-old gunshot victim spent hours in a small hospital while nurses frantically tried to find a large hospital and neurosurgeon to take him. Now would, so the family was told to have an ambulance to take him to the emergency room of a large hospital, McAllen Medical Center. By then, critical hours had passed, and the boy eventually died.

California also is seeing end-run around its strict laws. Some hospitals in the Los Angeles area, for example, are threatening to close unprofitable emergency rooms to all but private ambulances.

"One way or another, people aren't getting needed health care because they don't have enough money to buy it," says Lois Salisbury, an attorney with Public Advocates in San Francisco who helped lead the fight for an anti-dumping law. "The problem persists in new forms and outpaces . . . legislators."

Another "sordid variation of dumping," she says, consists of admitting and summarily releasing the uninsured after a quick once-over. Last year, an uninsured

27-year-old truck driver was admitted to a California hospital after persuading officials to accept \$500 instead of the \$1,000 they requested. The man, who had chest pain, was released the next day even though basic tests hadn't been conducted. Mr. Salisbury says. He was told to rest for a week and not lift anything heavy. Several hours later, the man died.

Mr. Salisbury believes hospitals will continue to find ways to avoid caring for the indigent until they get their money. The question is, how to reimburse them. Some health-care experts advocate creating a pool of funds from insurers and those hospitals that don't treat many poor patients to compensate hospitals that do. Others say new taxes, such as an income-based health insurance tax, will finance care. National health insurance is yet another possible course.

Whatever the solution, it promises to be financially painful, says Ms. Salisbury. Without a remedy, however, the casualties will increase, among the sick and families unable to afford proper care.

The legal aid attorney recalls the torment of a young mother whose son was injured in an automobile accident in Modesto, Calif. The family was told it had to pay, up front, for surgery. It didn't have the money, and the boy died. "The mother was distraught with guilt," says Ms. Salisbury. "She and her husband were working class, but they just couldn't come up with \$1,000 to try to save their son's life. That's what they must live with for the rest of their life."

Chairman STARK. Did you find any correlation between State procedures and laws like Texas and California have, where most of the places were identified because of the correlation?

Mr. KUSSEROW. There are five States that have special requirements that parallel the Federal requirement on antidumping. Leading the list are California and Texas, which have gone further than most States.

In the case of your home State, they have a requirement under California law that you have a posting of patient rights in the hospital and also that you have a transfer summary if you are in fact transferring somebody, to be sure you are not dumping them out of the hospital.

Texas similarly has a strong antidumping law and is ahead of the pack with regard to having memoranda of transfer on file. Now, I cannot say that that may be the full explanation of why there are more cases coming out of those States, but with that kind of evidence available in the hospital, a State survey and certification person can more easily find evidence of dumping and more easily deal with the problem.

I think probably more than anything else that is the one variable that would explain why reports are higher in those States than other States.

Chairman STARK. Mr. Gradison.

Mr. GRADISON. Thank you.

Mr. Kusserow, I have the impression, and this is strictly an anecdote, that in my own area, quite frequently patients with any choice in the matter, that is elective hospital requirements, that live in the rural areas are going in to the urban areas to seek care because they see it as higher technology and better quality. This makes it hard for the rural hospital to compete. I am talking about 50 or 60 driving miles and not all interstates either. Maybe it is an hour's drive.

In your study where you looked into the number of patients, you got into the mix of those patients and what they were there for. Do you have any impressions, for example, as to whether the remaining patients are more often emergencies which go there because there is no other place to go? Do you know of any data that would bear on these anecdotes?

Mr. KUSSEROW. It is clear that your information is the same as Secretary Sullivan when he first heard our briefing. Since that time, we have gone back to look more seriously about whether we can get those answers. We looked at the domino effect reflected in the chart. We know that a major factor as indicated from anecdotal information, was that physicians would refer patients to the hospital down the road, not the local one because they thought they would get better care.

I heard someone say earlier today that the patients were walking to a different hospital. The problem we have is that I cannot tell you definitively as to how often that does occur and quantitatively how those factors make the domino effect to take place that causes hospitals to go under.

In this coming year, we will be issuing other reports that will give you the answers to those questions. The Secretary says he wants this information, and as soon as I find out for him, I will

come to you and give you a better answer. I think it is all of the above.

The physicians are choosing to send their patients to the hospital 20 miles down the road because they think they will get better care than at the local hospital.

Mr. GRADISON. Thank you.

Chairman STARK. Mr. Levin.

Mr. LEVIN. Mr. Chairman, I don't have any questions. I was just rereading the report.

It is just so helpful to have this kind of professionally done analysis. It helps to have the facts. They don't always determine the issue, but it is very useful. We will be looking forward to your other reports as we try to wrestle with these issues.

As you leave, do you have any reactions to the discussion you heard earlier, the colloquy among the members?

Mr. KUSSEROW. My first reaction was the temptation to run out of the room, the discussion of Titans. But it does tell me there is a real informational need.

I don't think I can tell you what the answers are to these very vexing problems. Thank God I don't have to do that. But I can at least try to give you more information to allow you to make those decisions.

I think the reports coming out, the final analysis of those hospitals that did not make money last year, not just the ones that closed but the ones that did not make money and try to understand what is the difference between hospitals that do not make money and those that do. That should provide you with some additional insight.

I don't know that it will provide the answers, but you will have a better idea of factors of profitability, and you will have a better idea of those hospitals that are stressing out but still functioning.

Also, we will have hospitals grouped from the smallest to largest so you will see how many hospitals there are under 20 beds. If you have a 20-bed hospital, it is hard to meet Medicare standards, like 24-hour pharmacists and physicians when you have a 20-bed hospital with a 20- to 30-percent occupancy rate.

At least we will try to give you some comparative data between those who are under PPS versus those that are losing. What is the difference between full-time equivalent staffed beds? What are some of the other problems? And perhaps from these additional reports, which we will give you as quickly as we can, perhaps you might be able to find a solution.

Chairman STARK. I have one final question. Do you think that you have enough data on your study of hospitals that closed, rural hospitals, to go back and if you increased their Medicare fees by a certain percentage, would you look back and say retrospectively what might have happened to them in terms of their income and expense?

Mr. KUSSEROW. Yes. We have runs that have a list of all hospitals that have a lot of figures. It was not part of the report, but used in the working papers that would give you that kind of insight.

Chairman STARK. I have heard the figure, I guess 40 percent just to pick a number. But if you could run a 10-, 20-, 30-, 40-percent

increase for the 2 or 3 years, whatever figures you might have, on rural hospitals that closed, and just send us a letter and tell us if it would have saved them. Maybe they closed for other reasons. You said in some cases the doctors moved out of town.

Mr. KUSSEROW. In some cases, they were kicked out of medicare because of substandard care.

Chairman STARK. In those cases, would you give us some anecdotal information if they had more help?

Mr. KUSSEROW. Looking at the current year of PPS data, what I can probably do with it, let you see what would happen if the so-called playing field were level, according to what we heard earlier, what would happen and how it would change the picture. It becomes anecdotal if you are looking at 60 or 70 hospitals.

Chairman STARK. I would appreciate that very much. I again thank you for this.

Mr. KUSSEROW. I promised 30 days. Maybe you can give us a few days on top of that.

Chairman STARK. You may have a lot of confirmation hearings to attend. Your office sets a good standard in accuracy in reports, and I appreciate it very much.

Mr. KUSSEROW. Thank you, Mr. Chairman.
[The following was subsequently received:]

HOSPITAL CLOSURE: 1987



OFFICE OF INSPECTOR GENERAL
OFFICE OF ANALYSIS AND INSPECTIONS

MAY 1989

OFFICE OF INSPECTOR GENERAL

The mission of the Office of Inspector General (OIG) is to promote the efficiency, effectiveness, and integrity of programs in the United States Department of Health and Human Services (HHS). It does this by developing methods to detect and prevent fraud, waste, and abuse. Created by statute in 1976, the Inspector General keeps both the Secretary and the Congress fully and currently informed about programs or management problems and recommends corrective action. The OIG performs its mission by conducting audits, investigations, and inspections with approximately 1,200 staff strategically located around the country.

OFFICE OF ANALYSIS AND INSPECTIONS

This report is produced by the Office of Analysis and Inspections (OAI), one of the three major offices within the OIG. The other two are the Office of Audit and the Office of Investigations. Inspections are conducted in accordance with professional standards developed by OAI. These inspections are typically short-term studies designed to determine program effectiveness, efficiency, and vulnerability to fraud and abuse.

The purpose of this inspection, entitled "Hospital Closure: 1987," is to describe the phenomenon of hospital closures in the United States.

This inspection was performed under the direction of Linda Herzog, the Regional Inspector General of Region IV Office of Analysis and Inspections. Participating in the project were:

Atlanta Region

Ron Kalil (*Project Leader*)
Jim Wilson
Joe Townsel
Betty Davis
Paulette Roberts
Elizabeth Roper
Doug Marshall
Peggy Daniel
Chris Koehler

Headquarters

Cathaleen Ahern
Linda Moscoe

HOSPITAL CLOSURE: 1987

RICHARD P. KUSSEROW
INSPECTOR GENERAL

EXECUTIVE SUMMARY

PURPOSE

This inspection was conducted to describe the phenomenon of hospital closures in the United States. It examines the characteristics of, reasons for, and impact of closures in 1987.

BACKGROUND

In recent years, the closure of general, acute care hospitals has generated increasing public and congressional concern. According to recent studies, more hospitals are expected to close their doors in coming years. Numerous questions have been raised about the reasons for and the effects of hospital closure, as well as the implications for public policy. Legislation was passed in 1987 to provide Rural Health Care Transition Grants to help communities address the kinds of changes that may lead to hospital closure.

FINDINGS

This inspection found that for 1987:

Sixty-nine general, acute care hospitals closed. They were located in 27 States. Thirteen new hospitals opened in 1987, and 8 of the 69 which closed in 1987 reopened in 1988.

Rural and urban hospitals closed in roughly equal proportion to their numbers nationally.

Hospitals that closed were small. Rural hospitals that closed were about half the size of the average rural hospital. Urban hospitals that closed were just over one-third as large as the average urban hospital.

Occupancy rates for both rural and urban hospitals that closed were much lower than the national averages.

When compared to national norms, there were no significant differences in either the Medicare or the Medicaid utilization rates of hospitals that closed.

There was no single factor or event which caused hospitals to close. Rather, a set of factors relating to hospital financing gradually diminished hospital viability. Hospitals that closed were reported to have had:

- declining revenues due to fewer admissions, lower third-party reimbursement, and more uncompensated care; and
- rising costs due to increasing demands for new medical technology, skilled personnel, and facility maintenance, renovation, or replacement.

Emergency services and inpatient care are accessible to most people living in communities where hospitals closed in 1987.

SUMMARY

Hospitals that closed in 1987 were small and had low occupancy rates. When the hospitals closed, few patients were affected. Most could get medical care nearby.

FUTURE STUDIES

The Office of Inspector General will look further into actions communities can take to maintain access to medical care in the face of possible hospital closure.

TABLE OF CONTENTS

	Page
EXECUTIVE SUMMARY	
INTRODUCTION	1
Background	1
Purpose	1
Scope	1
Methods	1
FINDINGS	3
Extent and Nature of Hospital Closures	3
How many closed?	3
Where were they?	3
How many opened?	4
What were these hospitals like?	4
Why did they close?	7
Impact of Hospital Closures	11
How many patients were affected?	11
Is inpatient care accessible?	12
Is emergency care available?	12
What happened to the buildings?	13
Future Studies	14
NOTES	15
APPENDICES	
Appendix A: Methodology by Topic Area	A-1
Appendix B: Hospital Closure Charts	B-1

INTRODUCTION

BACKGROUND

Congress and the public have shown increasing interest in hospital closings. They raise concerns about access to inpatient care and emergency services, particularly for older people in rural areas.

The American Hospital Association (AHA) reported 96 hospitals closed in 1987. According to a 1984 study by Arthur Andersen & Company, health industry policymakers estimate that 700 of the nation's hospitals will have closed by 1995.¹ A recent Touche Ross survey found that 48 percent of 419 hospital executives believe their hospitals may fail within 5 years.² The Government Research Corporation estimates that over 40 percent of all hospitals in the United States will close or be converted to other uses by the year 2000.³

PURPOSE

This inspection was designed to describe the phenomenon of hospital closures in the United States. It examines the characteristics of, reasons for, and impact of these closures.

SCOPE

The study examined hospitals that closed in Calendar Year 1987, the latest year for which sufficient data are available on the characteristics of hospitals.

For purposes of this study, the following definitions were used:

Hospital: A facility that provides general, short-term, acute medical and surgical inpatient services.

Closed Hospital: One that stopped providing general, short-term, acute inpatient services in 1987. If a hospital merged with or was sold to another hospital and the physical plant remained open for inpatient acute care, it was not considered a closure. If a hospital closed and reopened in 1987, it also was not considered a closure.

METHODS

Information for this study was obtained from an AHA list of 1987 hospital closures and Health Care Financing Administration (HCFA) data bases. Additional information came from contacts with State hospital associations, State licensing and certification agencies, State health planning agencies, officials associated with closed hospitals or hospitals nearby, and local public officials.

When the AHA list was compared with HCFA data on Medicare hospitals and information from State Government agencies, only 61 of the 96 hospitals listed by the AHA fit the definitions used in this study.

The list comparison showed that 22 of the hospitals on the AHA list were psychiatric, rehabilitation and other specialty hospitals which did not meet the study criteria. Ten other hospitals on the list had closed in a year other than 1987. Three hospitals on the list were still operating. The inspection also uncovered eight hospital closures in 1987 that did not appear on the list.

More information appears in appendix A on data collection methods.

FINDINGS

The Inspector General's study of hospitals closed in 1987 found that:

- sixty-nine general, acute care hospitals closed in 1987;
- size and occupancy levels appear to be the major factors in hospital viability;
- because of the small size and low occupancy of hospitals that closed, few patients were affected; and
- hospital closures do not appear to have resulted in major health care access problems.

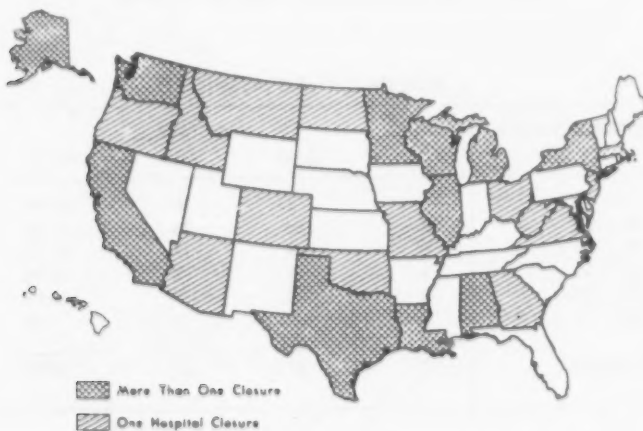
EXTENT AND NATURE OF HOSPITAL CLOSURES

How many closed?

In 1987, there were more than 6,800 hospitals in the United States. Of those, 5,143 were general, short-term, acute care hospitals shown in HCFA's data base as participating in the Medicare program. Forty-eight percent are rural and 52 percent are urban.

Sixty-nine hospitals closed in 1987--1.3 percent of all hospitals nationally. When they closed, the general acute care inpatient bed supply was reduced by 4,233 beds, or one-half percent.

Where were they?



The closed hospitals were located in 27 States. One-half of these States had only one hospital closure. The greatest number of closures was in Texas (14), followed by Michigan (6), California (5), and Minnesota (5). Appendix B shows a list of the 1987 closures and the number of rural and urban hospital closures by State.

Rural and urban hospitals closed at a rate roughly proportional to their numbers nationally. Thirty-seven of the closed hospitals (54 percent) were rural; 32 (46 percent) were urban.

	RURAL	URBAN
TOTAL: 5143	2,489 (48%)	2,654 (52%)
CLOSED: 69	37 (54%)	32 (46%)

How many opened?

While 69 hospitals closed in 1987, 13 new general, acute care hospitals opened, adding back 1,116 beds to the national bed supply. Eight of the 69 hospitals which closed in 1987 reopened in 1988, adding back 261 beds.

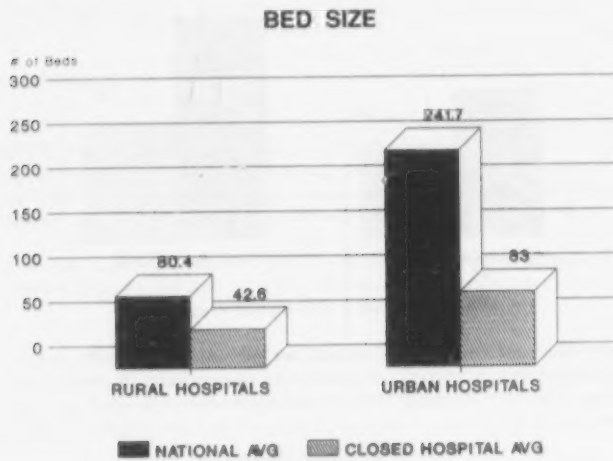
What were these hospitals like?

Size: Hospitals that closed in 1987 were small. Forty-three of them--almost two-thirds--had fewer than 50 beds. Only 12 had more than 100 beds.

SIZE OF CLOSED HOSPITALS

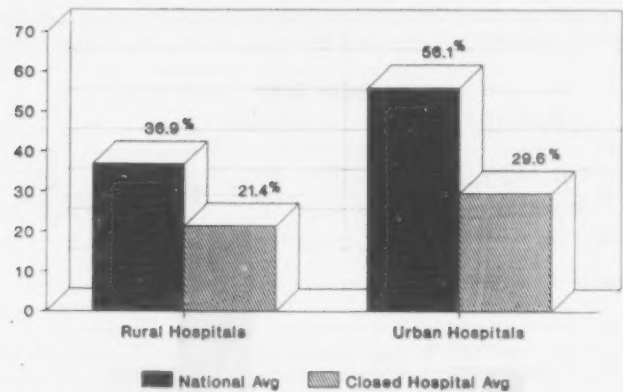
NUMBER OF BEDS	HOSPITALS			
	Rural	Urban	Total	Percent
0 - 29	15	5	20	29.0%
30 - 49	13	10	23	33.3%
50 - 99	6	8	14	20.3%
100 - 199	3	5	8	11.6%
200 - 299	0	4	4	5.8%
300 +	0	0	0	0%
TOTALS	37	32	69	100%

Compared to the *average* size of general, acute care hospitals nationally, both the rural and urban hospitals that closed in 1987 were a great deal smaller. Rural hospitals that closed were about half the size of the average rural hospital. Urban hospitals that closed were just over one-third as large as the average urban hospital nationally.



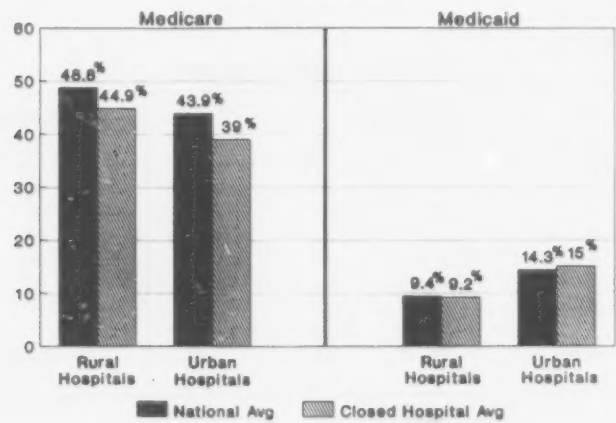
Occupancy: Occupancy rates for both rural and urban hospitals that closed in 1987 were much lower than the national averages.

OCCUPANCY⁴



Medicare and Medicaid Utilization: There was no significant difference in average Medicare occupancy between hospitals that closed and all hospitals nationally. Similarly, there were only marginal differences in average Medicaid utilization between hospitals that closed and all hospitals nationally.

UTILIZATION⁵



Medicare Compliance and Program Integrity: According to HCFA, five of the closed hospitals had been involuntarily removed from the Medicare program for failure to meet Medicare's conditions of participation. Further, HCFA had taken adverse actions against 11 more of the closed hospitals for noncompliance with conditions of participation in recent years.

Eleven of the closed hospitals had been reported to the Office of Inspector General's Office of Investigations for possible violations of Medicare or Medicaid laws. Of these 11 cases, 1 resulted in a civil monetary penalty; 1 resulted in administrative recoupment of Medicare funds; 3 were referred to the U.S. Attorney (but were not accepted for prosecution); 5 were closed with no violation found; and 1 case is pending.

Why did they close?

The many health care professionals interviewed in the course of this inspection reported no single reason for hospital closure. Rather, they suggested a number of factors which gradually weakened the financial condition of these hospitals. As occupancy declined, revenues lagged; but costs continued to rise. Operating margins shrank and ultimately there was no choice but to sell, merge with another hospital, or close the doors.

Declining Occupancy: Hospital occupancy is a function of the number of admissions and the lengths of hospital stay. Respondents cite fewer admissions as the main cause of declining occupancy.

Physicians control where patients are admitted for inpatient care. For most of the 69 hospitals that closed in 1987, physician referrals were said to have dwindled for a number of reasons:

- **Physician availability was a problem in rural areas.**

In several rural communities where hospitals closed in 1987, the town's physician retired, died, or moved his practice and no replacement was found.

Rural areas are less able to attract and retain physicians. The smaller population base often means that the physician practices alone and is always on call. Many physicians find rural practice, under these conditions, to be unattractive.

- **Physicians lost confidence in the local hospital.**

Many of the hospitals included in this study were old and needed renovation and modernization. They lacked the high technology diagnostic and treatment equipment which physicians value.

In cases where newer and better equipped hospitals are available nearby, physicians tend to shift their admissions to those facilities.

- **Patients, too, preferred other hospitals.**

People are becoming better informed about health and medical care. They want the best care available, and they are more likely to question quality. Although they may be uncertain how to measure quality in technical terms, many will choose a large hospital over a small one; a newer, better equipped facility over one which shows its age. Many of the hospitals which closed in 1987 did not inspire patient confidence.

- **Medicare peer review organizations (PRO) are more carefully scrutinizing the necessity of hospital admissions.**

The PROs are responsible for reviewing hospital admissions for appropriateness, and may sanction individual physicians for unnecessary hospitalization. Where there are only a few physicians admitting to a hospital, the likelihood of a physician being included in the PROs' sample increases. This factor is said to have made physicians more cautious in admitting marginally sick Medicare patients, which, consequently, has lowered hospital admissions.

A more subtle effect of the PROs' diligence is also at play. Patients who were less sick and *might* have been admitted before the advent of PRO review are less likely to be admitted. Without these "cheap cases," hospitals are less able to offset the higher cost of unquestionably necessary admissions.

- **Competition among hospitals is intense.**

People interviewed for this study reported that competition with other hospitals was a factor in many of the closures. Hospitals with limited resources are hard-pressed to compete with newer or larger hospitals which aggressively market their services, maintain a healthy capital reserve, and offer higher salaries to nursing and technical staff.

- **People are more mobile.**

With better roads and improved transportation there is increased access to distant medical facilities. Now physicians and their patients can choose a hospital on the basis of quality or reputation rather than solely on proximity.

- **Practice patterns are changing.**

Medical advances and new technology have allowed some procedures which formerly required a hospital stay to be performed on an outpatient basis.

One respondent noted that, as if competition by other *hospitals* were not enough, now hospitals are in competition with doctors, urgent care clinics, and surgical centers. With the added factors of better transportation and greater mobility, patients now have less expensive and more convenient alternatives to hospitalization.

Lagging Revenues: Lower occupancy means less income for hospitals. Other factors were also mentioned by respondents as reasons for declining hospital revenue:

- **Patients without hospital insurance, or with inadequate insurance, create substantial losses for the hospital.**

There are estimated to be 37 million people in the United States who have no medical insurance. Others carry minimal coverage for hospitalization.⁶ When hospitals admit these patients they accept losses which appear on the books as "charity" and "bad debt"—uncompensated care. In Mississippi, uncompensated care is reported to have totaled \$443 million in 1987, up almost \$70 million from 1986.⁷

Historically, hospitals covered these losses by "cost shifting" to patients who were insured or could afford to pay. Hospitals set their charges high enough to cover the cost of the insured patient's care *plus* a portion of the uncompensated care. More and more insurers are refusing to accept these cost shifts.

- **Insurers are better controlling their costs.**

Both public and private insurers are pressed to control their hospital outlays. Some have reduced the percentage of hospital charges or costs they will reimburse. Others have changed from charge-based reimbursement to paying a scheduled amount per case, usually based on diagnosis and intensity of care required.

Many respondents pointed out that, with these changes, payments from some insurers no longer cover the actual cost of care. Several mentioned Medicaid in particular.

When payments do not cover costs, hospitals must either recoup the difference from the patient, shift the cost to another payor, or take a loss.

- **Medicare pays rural hospitals less.**

Medicare reimbursement rates are based on average costs for the geographic area. Since rural costs have historically been lower than urban, rural hospitals' reimbursement rates are lower. Respondents suggested that hospitals classified as "rural" by HCFA but located in the same labor market as urban hospitals are particularly disadvantaged by such payment formulas.

Rising Costs: According to many respondents, hospital costs are rising despite efforts to curb them. On a per-case basis, costs increased by 9.5 percent in 1987 over 1986.⁸

Some of the important factors cited by respondents are:

- **New medical technology is a major capital expense.**

While beneficial in speeding up diagnosis and treatment, technology is very costly. If a hospital fails to provide this modern equipment to physicians, they will take their patients elsewhere. Small hospitals can least afford such purchases.

- **Labor costs are increasing, and nursing and technical staff are scarce.**

Shortages of skilled hospital personnel have made it difficult for hospitals to attract and retain staff. Rural hospitals in particular have problems competing in the regional and metropolitan markets. They must offer salaries equal to or better than suburban hospitals to balance the disincentives to rural medical practice.

- **Deteriorating facilities require major capital investments to renovate and modernize.**

Many of the hospitals that closed in 1987 are old facilities in need of repair or renovation. These alterations are expensive. With declining revenues, smaller hospitals are often unable to make the needed changes.

Health care planners, regulators, and hospital administrators contacted during the course of this inspection described these factors--occupancy, revenue, and cost--as intricately related and interdependent. Hospital viability was said to depend on the stability of all three. The weakening of one may begin a chain reaction eventually leading to hospital closure.

When a hospital's patient census begins to slide, patient revenues necessarily decline. If a substantial proportion of the remaining patients are uninsured and poor, the cost of providing care is no longer covered by operating revenue.

In order to make payroll and pay the bills, the hospital diverts funds which would ordinarily be deposited to capital reserves. Needed maintenance and renovation must then be postponed. The hospital forgoes purchase of expensive high technology equipment. Soon it is unable to compete with neighboring hospitals.

Physicians begin admitting their patients to other hospitals which better meet their needs. This further erodes occupancy and patient revenues. The hospital may make every effort to reduce its costs, which may diminish its attractiveness to doctors and patients even more. But fixed costs remain, and now must be supported by fewer and fewer patients.

The hospital's operating margin shrinks to the point that all possible solutions become too expensive. The range of options narrows to merger, sale, or closure.

Small hospitals are least able to defend against this downward spiral. Hospitals which closed in 1987 were significantly smaller than average. Every one of them was said to have encountered some or all of the problems described here.

IMPACT OF HOSPITAL CLOSURES

Through interviews with local hospital and Government officials, the inspection assessed:

- the number of patients affected;
- the availability of inpatient care;
- access to emergency medical services; and
- present use of the closed hospital buildings.

Inpatient and emergency care were found to be accessible to most communities where hospitals closed in 1987. Respondents indicated that access to care was less convenient for some, but not a major problem.

How many patients were affected?

Few patients were affected by hospital closure. For rural hospitals that closed in 1987, the average daily census was about nine patients. Therefore, when a rural hospital closed, presuming that those hospital stays were necessary and that the demand remained constant, only nine beds needed to be found nearby. In the urban areas, 25 beds needed to be found.

WHEN HOSPITALS CLOSED, HOW MANY PATIENTS WERE AFFECTED?

	Rural Hospitals	Urban Hospitals
Average Number of Beds	42.6	83.0
Average Occupancy Rate	x 21.4%	x 29.6%
Average Patient Census	9.1	24.6

Medicare utilization data were analyzed to determine the number of elderly affected by hospital closure. In rural hospitals that closed the average census was nine patients at the time of closure. Only four were Medicare beneficiaries. In urban hospitals that closed, only 10 of the average 25 occupied beds were filled by Medicare patients.

**WHEN HOSPITALS CLOSED,
HOW MANY MEDICARE PATIENTS WERE AFFECTED?**

	Rural Hospitals	Urban Hospitals
Average Patient Census	9.1	24.6
Average Medicare Utilization Rate	x 44.9%	x 39.0%
Average Medicare Patients	4.1	9.6

Is inpatient care accessible?

Urban: In urban areas whose hospitals closed, residents of only one community must travel over 10 miles for inpatient care. In Wasco, California, the nearest hospital is located 19 miles away in Delano.

One other urban community had a similar situation. During the time the hospital in New Boston, Texas was closed, residents had to travel 23 miles to Texarkana. However, New Boston General Hospital reopened in 1988.

Rural: In three-quarters of the rural communities studied, another general hospital is located within 20 miles. Prior to the closure of these rural hospitals, many residents and physicians were already bypassing the local hospital and traveling to other nearby facilities for care.

Residents of only three of the 37 rural communities must travel further than 30 miles for inpatient care. In San Manuel, Arizona, residents must go 50 miles to one of several hospitals located in Tucson. In Mullen, Nebraska, the nearest hospital is located 75 miles away in North Platte. In Alaska, Glennallen's Faith Hospital no longer operates as a full-service hospital, but provides emergency care to stabilize patients before they are transported by air to Anchorage 200 miles away.

Is emergency care available?

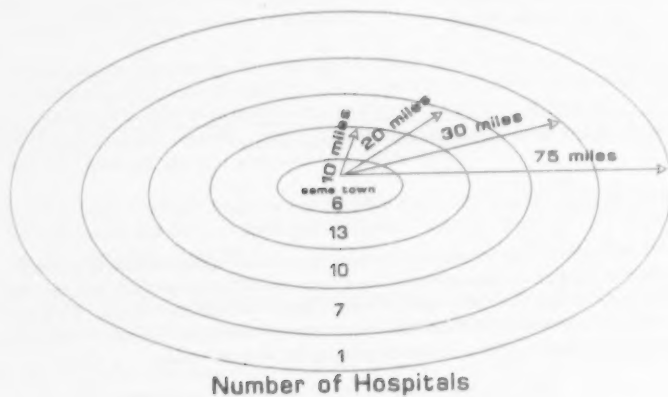
When a hospital closes, the community loses not only inpatient beds, but also emergency services. Generally, respondents did not report significant problems with access to emergency care in the communities studied in this inspection. In rural areas, where more problems might be expected, emergency stabilization and transportation systems are said to work rather well overall.

Urban: In urban areas, all but one of the 32 communities whose hospitals closed in 1987 had emergency care available within 10 miles. Most urban communities have several hospitals

which provide both inpatient and emergency care, so the closure of one hospital has little effect on the community's emergency care system. Residents of only one community studied here--Wasco, California--have to travel further, to Delano 19 miles away.

Rural: In only eight of the 37 rural communities whose hospitals closed, residents had to travel more than 20 miles for emergency care. In those eight communities, ground or air ambulance services were available. Only in Mullen, Nebraska was the travel time over 30 minutes, to North Platte about an hour's ride by ambulance.

When Rural Hospitals Close.... WHAT ABOUT EMERGENCIES?



What happened to the buildings?

In almost half of the 69 cases of 1987 hospital closures, the former hospital buildings are now used for some health care purpose.

Prior to discontinuing general, acute inpatient care, several hospitals provided more than one type of service. For example, Ashton Memorial Hospital in Idaho provided both acute and long-term care services. In 1987, the hospital closed its general, acute care services. It opened a chemical dependency unit and continues to offer nursing home care.

Other facilities were converted to a different type of health care use. Jay Memorial Hospital in Jay, Oklahoma, for example, is now a clinic. The following chart illustrates the current use of all 69 hospitals closed in 1987.

CURRENT USE OF HOSPITALS CLOSED IN 1987		
Use	Number of Hospitals*	
	Rural	Urban
Reopened Hospital	4	4
Speciality Treatment Facility (e.g. chemical dependency)	3	3
Long Term Care Facility	7	1
Outpatient Services/Clinic	4	12
Offices	1	2
Vacant	20	14

*Duplicate count. Eight of the 69 hospitals provide two separate services.

FUTURE STUDIES

The OIG will look further into actions communities can take to maintain access to medical care in the face of possible hospital closure. Some communities have carefully analyzed their needs and are constructing affordable medical care systems that meet their needs. The OIG's follow-up analyses are intended to learn what steps these communities have taken and to make that information available to other communities facing the same dilemmas.

NOTES

1. Arthur Anderson & Co. and the American College of Hospital Administrators. *Health Care in the 1990s: Trends and Strategies*. 1984.
2. Touche Ross. *U.S. Hospitals: The Future of Health Care*. June 1988.
3. Larry S. Gage, Dennis P. Andrulis, and Virginia Beers, *American's Safety Net: A Report on the Situation in Our Nation's Metropolitan Areas*. National Association of Public Hospitals. October 1987.
4. Hospital occupancy rate is defined as the actual number of patient days divided by the total bed days available. National occupancy rate is defined as the sum of all hospitals' occupancy rates, divided by the number of hospitals.
5. Average Medicare utilization for closed urban and rural hospitals is defined as the percent of Medicare patient days compared to total patient days for each hospital, summed and divided by the number of hospitals. National average Medicare utilization is the percent of Medicare utilization for each hospital, summed and divided by the total number of hospitals. Medicaid utilization is calculated in the same way.
6. Larry S. Gage, Dennis P. Andrulis, and Virginia Beers, *American's Safety Net: A Report on the Situation in Our Nation's Metropolitan Areas*. National Association of Public Hospitals. October 1987. Page 20.
7. Survey by the Mississippi Hospital Association as reported by *Health Week*, June 6, 1988. Page 11.
8. Carol McCarthy, President of the American Hospital Association. Testimony to U.S. House of Representative Committee on the Budget. August 1, 1988.

APPENDIX A

METHODOLOGY*Phenomenon of closures*

To determine how many hospitals closed in 1987, the study was started with a list from the AHA. The list was compared with the list of Medicare hospital terminations in 1987 in HCFA's Health Standards and Quality data base (RADARS). All 50 State licensing and certification agencies were contacted. State hospital associations and State health planning agencies also were contacted. When closures were found that met the definition of hospital closures or when discrepancies in data were found, contacts were made with officials associated with the closed hospitals and officials associated with the hospital nearest to the closed hospital.

To determine the number of hospitals in the U.S. and the bed capacity, the Hospital Cost Report Information System (HCRIS) maintained by HCFA was used. Only the general, short-term, acute care hospitals under Medicare's Prospective Payment System (PPS) were included in the universe. Five thousand one hundred fifty (5,150) hospitals were listed, less 7 with no data reported, which left 5,143. This was the universe of short-term, acute care, general hospitals on HCRIS for the fourth year of PPS (PPS 4).

Characteristics of closed hospitals

To analyze characteristics of closed hospitals, HCFA's HCRIS data were used. Cost reports were not available for 3 of the 69 closed hospitals. Two were not Medicare providers in the years prior to closure and one had not submitted a cost report since PPS began. For the remaining 66 hospitals, the latest cost reports prior to closure containing sufficient data were used. For example, if a hospital closed in October 1987 and its accounting year was on a July-June cycle, the provider's July 1, 1986 to July 20, 1987 report was used. Cost report data on 49 of the 69 hospitals were contained in HCRIS for PPS 4, and data on 61 of the 69 hospitals were contained in HCRIS for PPS 3.

Reasons for hospital closures

To determine the reasons for 1987 closures, officials of the following agencies were contacted:

- State hospital associations
- State health planning agencies
- State certification and licensing agencies
- closed hospitals; and
- nearest hospitals to closed hospitals.

Impact of hospital closures

The "impact" issues examined concentrated on those relating to access to medical care. To determine these impacts, many of the following were contacted:

- former hospital administrators, board members, and/or staff;
- hospital administrators and/or staff at the nearest hospitals;
- local police and health officials;
- local government officials,
- State health planning agencies;
- State certification and licensing agencies; and
- State hospital associations.

APPENDIX B

1987 HOSPITAL CLOSURES

Number of Closures by State		Number of Rural	Number of Urban
Texas	14	8	6
Michigan	6	0	6
California	5	1	4
Minnesota	5	2	3
Illinois	4	2	2
Louisiana	4	3	1
Alabama	3	3	0
Arkansas	3	3	0
Washington	3	0	3
Massachusetts	2	0	2
Nebraska	2	2	0
New York	2	0	2
Wisconsin	2	2	0
Alaska	1	1	0
Arizona	1	1	0
Colorado	1	0	1
Georgia	1	1	0
Idaho	1	1	0
Missouri	1	1	0
Montana	1	1	0
North Dakota	1	1	0
New Jersey	1	0	1
Ohio	1	1	0
Oklahoma	1	1	0
Oregon	1	0	1
Virginia	1	1	0
West Virginia	1	1	0
27 States	69 Closures	37 Rural	32 Urban

1987 HOSPITAL CLOSURES
By Name and Location

Hospital Name	City	State	Rural/Urban
Faith Hospital	Glennallen	AK	rural
Guin Hospital	Guin	AL	rural
Livingston-Tombigbee	Livingston	AL	rural
John Andrew Community Hospital	Tuskegee Institute	AL	rural
Delta Medical Center	Brinkley	AR	rural
Gurdon Municipal Hospital	Gurdon	AR	rural
Lafayette County Memorial Hospital	Lewisville	AR	rural
San Manuel Division Hospital	San Manuel	AZ	rural
Kingsburg General Hospital	Kingsburg	CA	urban
Shasta General Hospital	Redding	CA	urban
North Kern Hospital	Wasco	CA	urban
Corning Memorial Hospital	Corning	CA	rural
Buena Park Community Hospital	Buena Park	CA	urban
Memorial Hospital	Greeley	CO	urban
Fort Gaines/Clay County Hospital	Ft. Gaines	GA	rural
Ashton Memorial Hospital	Ashton	ID	rural
Saunders Hospital	Avon	IL	rural
Provident Medical Center	Chicago	IL	urban
Walther Memorial Hospital	Chicago	IL	urban
Paxton Community Hospital	Paxton	IL	rural
Dixon Memorial Hospital	Denham Springs	LA	urban
Catahoula Memorial Hospital	Jonesville	LA	rural
Leesville General Hospital	Leesville	LA	rural
Regent Hospital Acadiana	Erath	LA	rural
Mary A. Alley Hospital	Marblehead	MA	urban
Parkwood Hospital	New Bedford	MA	urban
Lakeshore Hospital	Detroit	MI	urban
Metro Hospital & Health Center	Detroit	MI	urban
Milton Community Hospital	River Rouge	MI	urban
A. Blain Hospital	Detroit	MI	urban
Detroit Memorial Hospital	Detroit	MI	urban
Springwells Health Center	Dearborn	MI	urban
St. John's Hospital	Browerville	MN	rural
Community Memorial Hospital	Clarkfield	MN	rural
Samaritan Hospital	St. Paul	MN	urban
St. John's Eastside	St. Paul	MN	urban
Mounds Park Hospital	St. Paul	MN	urban
Poplar Bluff Hospital	Poplar Bluff	MO	rural
Missoula General Hospital	Missoula	MT	rural

1987 HOSPITAL CLOSURES
By Name and Location

Hospital Name	City	State	Rural/Urban
Rolette Community Hospital	Rolette	ND	rural
Grand Island Memorial Hospital	Grand Island	NE	rural
Pioneer Memorial Hospital	Mullen	NE	rural
South Bergen Hospital	Hasbrouck Heights	NJ	urban
Baptist Medical Center	Brooklyn	NY	urban
Sheridan Park Hospital	Tonawanda	NY	urban
Southern Hills Hospital	Portsmouth	OH	rural
Jay Memorial Hospital	Jay	OK	rural
Cascade Community Hospital	Central Point	OR	urban
Shelby General Hospital	Center	TX	rural
Foard County Hospital	Crowell	TX	rural
Dallas Medical & Surgical	Dallas	TX	urban
Northpark Hospital	El Paso	TX	urban
Continental Hospital North	Ft. Worth	TX	urban
Deaton Hospital	Galena Park	TX	urban
Hamilton General Hospital	Hamilton	TX	rural
Hospital in the Pines	Lone Star	TX	rural
Meridian Hospital	Meridian	TX	rural
New Boston General Hospital	New Boston	TX	urban
Rosebud Community Hospital	Rosebud	TX	rural
Brazos Valley Hospital	Sealy	TX	rural
Wortham Hospital	Wortham	TX	rural
Ysleta General Hospital	El Paso	TX	urban
Wytheville Hospital	Wytheville	VA	rural
Northgate General Hospital	Seattle	WA	urban
Shorewood Osteopathic	Seattle	WA	urban
Pacific Medical Center	Seattle	WA	urban
Algoma Memorial Hospital	Algoma	WI	rural
Buffalo Medical Center	Mondovi	WI	rural
Stevens Clinical Hospital	Welch	WV	rural



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

JUL 19 1989

The Honorable Fortney B. Stark
Chairman, Subcommittee on Health
Committee on Ways and Means
House of Representatives
Washington, D. C. 20515

JUL 24 1989

Dear Mr. Stark:

At your Subcommittee's recent hearing on rural hospitals, we testified about our study of hospital closures and our findings that were summarized in our report entitled Hospital Closure: 1987. Our report discussed the financial and other reasons that hospitals discontinued operations and closed in 1987. During the hearing, representatives of rural hospitals testified that rural hospitals are disadvantaged under Medicare's prospective payment system because prospective payment rates for rural hospitals are lower than payment rates for urban hospitals. Therefore, you requested this office to determine how the 37 rural hospitals that closed in 1987 would have been affected by Medicare reimbursement based on urban prospective payment rates. Our enclosed report provides the requested information.

We reviewed available financial information from two Medicare cost reporting periods for 34 of the 37 closed rural hospitals, including the fiscal year in which they closed and the prior year (data was not available on three hospitals). We computed actual profit and loss rates in the 2 years for each hospital individually and in the aggregate. We then constructed a mathematical model which "urbanized" the Medicare diagnosis related group (DRG) payments made to these rural providers. Our model estimated (simulated) each facility's Medicare revenues as though the hospital had been paid as a hospital located in the nearest urban area. We then compared actual profit and loss rates to simulated rates for the 2 years reviewed.

Many supporters of rural hospitals argue that these providers are severely disadvantaged since rural DRG rates are lower than urban DRG rates. They maintain that the financial condition of all rural hospitals would

Page 2 - The Honorable Fortney H. Stark

significantly improve if rural hospitals were paid at the same rates used to pay urban hospitals. Our study does not support their viewpoint with respect to closed rural hospitals. As shown in the following schedule, the use of urban DRG rates in paying for hospitalized Medicare patients did not produce profits in 56 percent of these hospitals in the year before their closure or in 90 percent of these hospitals in the year of closure.

	<u>Total Hospital Operations</u>	
	<u>Actual Results</u>	<u>After Use of Urban Rate</u>
<u>Year Before Closure</u>		
Profitable hospitals	7	15 (44%)
Unprofitable hospitals	27	19 (56%)
Total profit or loss (In millions)	-\$10.46	-\$ 3.82
Profit Margin	- 12.39%	- 4.19%
<u>Year of Closure</u>		
Profitable hospitals	2	3 (10%)
Unprofitable hospitals	28	27 (90%)
Total profit or loss (In millions)	-\$20.38	-\$17.32
Profit Margin	- 51.99%	- 40.97%

Factors unrelated to Medicare DRG payments such as hospital size (and discharges) and occupancy rates appear to be more related to a rural hospital's financial success. Our review showed that the average rural hospital discharges 1,876 Medicare and non-Medicare patients each year in contrast to the closed rural hospitals which averaged about 700 discharges a year. Medicare discharge data showed a similar pattern. Each year these closed hospitals cared for about 240 Medicare patients while the typical rural facility treated about 700 Medicare beneficiaries. In addition, the 25 percent total occupancy rate for these closed hospitals was significantly less than the 40 percent occupancy rate experienced by the average rural facility.

83

Page 3 - The Honorable Fortney H. Stark

We hope this information is responsive to your request. If you need further information, please let us know.

Sincerely yours,



Richard P. Kusserow
Inspector General

Enclosure

EFFECT OF APPLYING URBAN
PROSPECTIVE PAYMENT SYSTEM RATES
TO THE 37 RURAL HOSPITALS CLOSED IN 1987



OFFICE OF INSPECTOR GENERAL

OFFICE OF AUDIT

CIN: A-07-89-00216

EXECUTIVE SUMMARY

In response to the request of the Chairman, Subcommittee on Health of the Committee on Ways and Means, this report shows how the profitability of the 37 rural hospitals that closed in 1987 would have been affected by Medicare urban prospective payment rates. The Office of Inspector General's (OIG) May 1989 report entitled "Hospital Closure: 1987" discussed the reasons for these hospital closures but did not show how increased Medicare funding under urban rates would have changed their financial condition. We recomputed their Medicare prospective payments for both the period prior to the fiscal year of hospital closure (or the most recent period for which data was available), and the fiscal year of hospital closure, by applying urban Medicare rates in place of the rural rates.

For the period prior to the fiscal year of hospital closure, our review showed that:

- o Total Hospital Operations - Based on the 34 hospitals for which data was available, overall losses totaled \$10.46 million (-12.39 percent) on overall revenues of \$84.45 million. Seven hospitals reported overall profits for this period and 27 hospitals reported overall losses.
- o Total Hospital Operations - If urban Medicare rates had been used to reimburse these hospitals, we estimate they would have received additional revenues of \$6.64 million, reducing their aggregate losses to \$3.82 million (-4.19 percent). For this period, the use of urban rates would have increased the number of profitable hospitals from 7 to 15; however, 19 hospitals (56 percent) would still not have been profitable.
- o Medicare Inpatient Activities - These 34 hospitals had aggregate losses totaling \$3.35 million (-16.04 percent margin) from their Medicare operations based on revenues of \$20.89 million. Individually, 8 of the hospitals earned Medicare profits and 26 hospitals incurred Medicare losses.
- o Medicare Inpatient Activities - If these 34 hospitals had been reimbursed under Medicare urban rates, Medicare revenues would have increased by 31.78 percent to \$27.53 million, allowing the hospitals to realize profits totaling \$3.29 million (11.95 percent)

and increasing the number of Medicare-profitable hospitals from 8 to 20. Conversely, 14 hospitals would have incurred Medicare losses under urban rate reimbursement.

The above information is summarized in the following chart and Appendix A presents selected financial data for each hospital for the year prior to its closure.

Number of Hospitals/Profitability	Application of Urban Rate Increase			
	Total Hospital		Medicare	
	Before	After	Before	After
Period Prior to Fiscal Year of Closing:				
Profitable	7	15	8	20
Unprofitable	27	19	20	14
Total	34	34	34	34
Profit or Loss (In Millions)	-\$10.46	-\$5.82	-\$3.35	\$3.29
Profit Margin	<u>-12.39%</u>	<u>-4.19%</u>	<u>-16.04%</u>	<u>11.95%</u>

For the fiscal year of hospital closure, our review showed that:

- Total Hospital Operations - The 30 hospitals for which data was available realized overall revenues of \$39.2 million. Individually, 2 hospitals reported overall profits for this period and 28 incurred losses. If urban Medicare rates had been used to reimburse these hospitals, we estimate that they would have received additional revenues of \$3.06 million.
- Total Hospital Operations - Since overall costs totaled \$59.58 million, the effect of urban rates would have been to reduce overall losses from \$20.38 million (-51.99 percent) to \$17.32 million (-40.97 percent). While urban rates would have improved operating margins for these hospitals, only one additional hospital would have been profitable; two hospitals were profitable under rural rates, while three would have been profitable under urban rates. Conversely, 27 hospitals would have incurred overall losses under urban Medicare reimbursement.
- Medicare Inpatient Activities - Considering only Medicare operations, the 30 hospitals had losses totaling \$3.28 million (-28.55 percent margin) on revenues of \$11.48 million. Under urban rates, the revenues would have increased by 26.66 percent to \$14.54 million, reducing the total losses to \$214,517 (-1.48 percent). The number of Medicare-profitable

hospitals would have increased from 3 to 8 and hospitals incurring Medicare losses would have decreased from 27 to 22.

A summary of their profits is shown below and Appendix B presents selected financial data for each hospital for the year in which it closed.

Number of Hospitals/Profitability	Application of Urban Rate Increase			
	Total Hospital		Medicare	
	Before	After	Before	After
Fiscal Year of Closing:				
Profitable	2	3	3	8
Unprofitable	28	27	27	22
Total	30	30	30	30
Profit or Loss (In Millions)	<u>-820.38</u>	<u>-817.32</u>	<u>-83.28</u>	<u>-80.21</u>
Profit Margin	<u>-27.69%</u>	<u>-27.24%</u>	<u>-27.76%</u>	<u>-26.74%</u>

Our analysis showed that the rural hospitals' profitability status was more related to the lack of utilization or number of discharges than to the amount of reimbursement. These hospitals suffered from low utilization. On average, both their number of discharges and their occupancy rates were significantly lower than the average for rural hospitals nationally, as discussed below:

- o The annualized number of overall discharges for these hospitals averaged 675 for the period prior to the fiscal year in which the hospitals closed, and 574 for the fiscal year in which the hospitals closed. In contrast, our data for about 2,200 rural hospitals nationally indicated that the average hospital discharged an average of 1,876 patients annually during the period 1985-1987. Medicare discharge data traces a similar pattern, 262 and 205, respectively, for the closed hospitals, compared to the national average of 700.
- o The closed hospitals were 24.88 percent occupied during the prior period, and 20.81 percent occupied during the fiscal year of closure, while rural hospitals nationally averaged 40.41 percent occupancy during the 1985-1987 period. These closed hospitals, on average, had patients occupying only 10 of the 42 beds available every day, with Medicare patients in 4 of the 10 beds.

HISTORICAL PERSPECTIVE

In computing separate urban and rural hospital rates, the Health Care Financing Administration (HCFA) determines the national average standardized discharge amount for the urban and rural hospitals. The current national average standardized amount consists of the 1984 average standardized amount with adjustments over the years for annual update factor increases, non-physician Part B services, outlier payments, disproportionate share amounts, indirect medical education costs, budget neutrality considerations, and other. The national average standardized discharge amount includes a labor related component (salaries, wages, and other labor related costs) and non-labor costs (supplies, utilities, drugs, et cetera).

Because of variances in labor costs, separate wage indexes are developed and applied to the urban and rural labor components of the national average standardized amount. The 1989 national wage index for urban areas averaged .956 for 318 metropolitan areas. The 1989 national wage index for rural hospitals averaged .8456 for 48 states (excluding New Jersey and Rhode Island which have no rural counties). Thus, the rural hospitals' national wage index is approximately 11.6 percent lower than the urban hospitals' national wage index.

After adjusting the national standardized amount by the wage index, the basic prospective payment then is finally derived by multiplying the national average adjusted standardized amount by the appropriate diagnosis-related group (DRG) value representing the type of medical service. The average of these DRG values during the year becomes the hospital's case mix index. A review of the prospective payments for the fourth year (1987) showed that urban hospitals had an overall case mix index average of 1.2082 compared to the rural hospitals' average of 1.0557. Thus, the rural hospitals' case mix index is approximately 12.6 percent lower than the urban hospitals' case mix index.

The basic DRG prospective payment amount does not include, for either urban or rural hospitals, the additional prospective payment amounts for such items as indirect medical education, outliers, and pass-through costs of direct medical education and capital costs.

OBJECTIVES AND STUDY PROTOCOL

The OIG report entitled Hospital Closure: 1987 provided numerous reasons why rural hospitals closed in 1987, but did not disclose the financial condition of these hospitals. At the May 15, 1989 hearing before the Subcommittee on Health of the House Ways and Means Committee, the HHS Inspector General was requested to determine what the financial condition of these 37 closed rural hospitals would have been had these hospitals been reimbursed their Medicare prospective payments by applying urban rates rather than their rural rates.

In general terms, our study utilized a mathematical simulation in which actual financial data were compared to simulated data - i.e., data computed by our mathematical model. Features of our study include the following:

- o Comparisons were made for two fiscal periods for each hospital. We used, where available, the hospital's cost report data, both for the last available period prior to the fiscal year of closing, and for the fiscal year of closing. Only 35 of the 37 closed hospitals had cost reports available. Cost reports covering the period prior to the fiscal year of closing (or the most recent period for which cost data was available) were available for 34 of the 35 hospitals. Of these reports, 30 covered a 365-day period; the remaining 4 reports covered periods ranging from 214 days to 379 days. The cost reports used were from the Hospital Cost Report Information System (HCRIS) database files maintained by HCFA's Bureau of Data Management and Strategy, Cost Report Analysis Branch, Baltimore, Maryland. Cost reports covering the fiscal year of closing were available for 30 of the 35 hospitals; these reports covered periods averaging about 8.5 months.
- o Our simulation model changed only Medicare DRG inpatient revenues. We did not make any change to Medicare operating or pass through cost items. We did not change the costs and related revenues of non-Medicare patients.
- o Our simulation model changed two items in the computation of Medicare DRG payments. Our model "reprices" each rural hospital's DRG revenue by replacing its actual (rural) standardized amount and wage index with the nearest urban standardized amount and wage index.

- o In addition, we did not disaggregate any hospital's actual DRG payment into national, regional, or hospital specific portions. We assumed the actual payments were made as if they were as a 100 percent national rate.
- o Subsequent to simulating the change in the amount of revenue, we recomputed each hospital's profit margin, a generally recognized measure of relative profitability. The margin is computed by dividing the amount of profit/loss by total revenues.
- o For each of the two fiscal periods for each of the closed hospitals, we computed two margins. These margins are shown on Appendix A and B. The "Medicare Inpatient" margin contains data related to the inpatient costs and revenue of caring for Medicare patients only. The "total hospital" margin is all-inclusive; it contains data for Medicare and non-Medicare patients, as well as non-patient care activities conducted by each hospital.

Other technical details are presented in the notes to the attached appendices.

RESULTS OF SIMULATION

Our simulation showed that if the closed hospitals had received the basic PPS urban payment rates rather than actual rural rates, the profitable hospitals in the period prior to the fiscal year of closing would have increased from 7 to 15 on an overall basis; and from 8 to 20 on a Medicare-only basis. For the fiscal year of closing the hospitals would not have benefitted as much from application of the urban rates. The number of profitable hospitals would have increased from 2 to 3 based on overall operations and from 3 to 8 based on Medicare operations.

For the period prior to the fiscal year of hospital closure, based on 34 hospitals for which complete data were available, we found that these rural hospitals had actual total hospital losses of \$10.46 million (-12.39 percent of overall revenues of \$84.45 million. We estimate that these hospitals would have received \$6.64 million of additional revenues if urban Medicare rates had been used, thereby reducing their total hospital losses to \$3.82 million (-4.19 percent). For this period, the use of urban rates would have increased the number of profitable hospitals from 7 to 15; however, 19 hospitals would still not have

been profitable. These hospitals had actual losses of \$3.35 million (-16.04 percent) from their Medicare inpatient operations based on revenues of \$20.89 million. If these hospitals had been allowed to use urban rates, Medicare revenues would have increased by 31.78 percent to \$27.53 million, allowing the hospitals to realize profits of \$3.29 million (11.95 percent), and increasing from 8 to 20, the number of Medicare-profitable hospitals. Details are presented on Appendix A.

We found that for the fiscal year of hospital closure the 30 hospitals for which data was available actually realized total hospital revenues of \$39.20 million. If urban Medicare rates had been used, we estimate that these hospitals would have received additional revenues of \$3.06 million. Since total hospital costs totaled \$59.58 million, the effect of applying urban rates would have been to reduce total hospital losses from \$20.38 million (-51.99 percent) to \$17.32 million (-40.97 percent). While urban rates would have improved operating margins for these 30 hospitals, only one additional hospital would have been profitable; two hospitals were profitable under rural rates, while three hospitals would have been profitable under urban rates. Considering only Medicare inpatient operations, the 30 hospitals had losses totaling \$3.28 million (-28.55 percent margin) on revenues of \$11.48 million. Under urban rates, the revenues would have increased by 26.66 percent or to \$14.54 million, reducing the total Medicare losses to \$214,537 (-1.48 percent). The number of Medicare-profitable hospitals would have increased from 3 to 8. Details are presented on Appendix B.

Although increasing the revenues by use of urban rates would have aided a few of the closed hospitals, our analysis of their overall and Medicare financial status showed that most of these hospitals suffered more from low utilization and higher costs per discharge caused by problems related to low occupancy, a low number of discharges, and a high number of employees per patient.

Other similar problems cited in the OIG report for these hospitals closing were (1) showing operating losses as a result of having about one-half as many beds as the average rural hospital, (2) suffering declining revenues due to fewer admissions, (3) receiving less third-party reimbursement, (4) providing more uncompensated care, and (5) experiencing rising costs due to increasing demands for new medical technology, skilled personnel, and facility maintenance, renovation, or replacement.

Details of Urban Rates Effect

We found that almost one-half of the closed hospitals would have made profits overall if they had received the Medicare urban rates in the fiscal year preceding the fiscal year of closure. However, in the months before closing, only one additional hospital would have been profitable overall. Medicare profitability would have been greatly enhanced in the fiscal year prior to closing, as the number of profitable hospitals would have increased from 8 to 20. However, only 5 additional hospitals would have made Medicare profits in the fiscal year of closing; the number of profitable hospitals would have increased from 3 to 8.

Number of Hospitals/Profitability	Application of Urban Rate Increases			
	Total Hospital		Medicare	
	Before	After	Before	After
Period Prior to Fiscal Year of Closing:				
Profitable	7	15	8	20
Unprofitable	27	12	28	14
Total	34	27	36	34
Profit or Loss (in Millions)	<u>-\$10.46</u>	<u>-\$3.82</u>	<u>-\$3.35</u>	<u>\$3.29</u>
Profit Margin	<u>-31.35%</u>	<u>-14.19%</u>	<u>-9.31%</u>	<u>9.95%</u>
Fiscal Year of Closing:				
Profitable	2	3	3	8
Unprofitable	28	27	27	22
Total	30	30	30	30
Profit or Loss (in Millions)	<u>-\$20.38</u>	<u>-\$17.32</u>	<u>-\$3.28</u>	<u>-\$0.21</u>
Profit Margin	<u>-67.93%</u>	<u>-57.73%</u>	<u>-10.93%</u>	<u>-0.70%</u>

The closed hospitals incurred \$10.46 million in overall losses in the period prior to the fiscal year of closing, and \$20.38 million in overall losses in the fiscal year of closing. Had these hospitals been reimbursed at urban rates, the losses would have been reduced to \$3.82 million and \$17.32 million, respectively.

Medicare losses, before applying the urban rates, were \$3.35 million for the period before the fiscal year of closing, and \$3.28 million for the fiscal year of closing. After applying the urban rates, Medicare showed a profit of \$3.29 million in the period before the fiscal year of closing, and a loss of \$0.21 million in the fiscal year of closing.

As described in the section entitled "Objectives and Study Protocol", our model changed only two components of the

prospective payment. We substituted (a) the urban for the rural standardized amount and (b) the urban wage index for the rural wage index. Our analysis showed that approximately two thirds of the increase in profit resulted from the change in the standardized amount and the remaining one third from the change in the wage index.

Low Utilization -- Discharges and Occupancy

Our analysis showed that these hospitals suffered from low utilization since, on the average, both their number of discharges and their occupancy rate were significantly lower than the average for rural hospitals nationally. The annualized number of overall discharges averaged 675 for the period prior to the fiscal year of closing and 574 for the fiscal year of closing. In contrast, our data for about 2,200 rural hospitals nationally indicated that the average hospital discharged 1,876 patients annually during the period 1985-1987. Medicare discharge data traced a similar pattern, 262 and 205, respectively, for the closed hospitals, compared to the national average of 700. Since Medicare payments under PPS are discharge driven, the low volume of discharges translates into lower Medicare revenues. Furthermore, to the extent that proposed changes in the payment system are also discharge driven, hospitals with low discharge rates would not benefit from these changes to the same extent as hospitals with higher discharge rates.

When hospitals suffer from low utilization the hospitals are unable to spread their fixed costs (certain administrative personnel, basic maintenance costs, base nursing staff, et cetera) over enough discharges; therefore, the cost per discharge exceeds the revenue per discharge. Ideally, the revenue from an individual patient should be sufficient to cover the variable costs (supplies, drugs, meals, et cetera) associated with that patient and a proportionate share of the hospital's fixed costs. If a 100 bed hospital has 100 patients, each must contribute 1 percent of the fixed costs. If the same hospital has just 50 patients, each must contribute twice as much. Hospital volume would not matter if a hospital could continually raise its charges to ensure that its fixed costs would be met by whatever number of patients it had. However, if there are limits on patients' ability to pay or the willingness of insurers to meet additional charges, falling volume will eventually result in an inability to meet fixed costs.

The closed hospitals were 24.88 percent occupied during the period prior to the fiscal year of closure, and 20.81 percent occupied during the fiscal year of closure, while rural hospitals nationally averaged 40.41 percent occupancy. As a result of the low number of discharges these closed hospitals on the average had patients occupying only 10 of the 42 beds available every day, with Medicare patients in 4 of the 10 beds.

According to the OIG report on hospital closure, the low utilization occurred due to physician availability, physicians losing confidence in the hospitals, patients preferring other hospitals, more scrutiny of hospital admissions by Medicare peer review organizations (PRO), intense competition among hospitals, mobility of people, and changing medical practice patterns. Other factors cited were problems with parent company bankruptcy (affected 8 of the 35 hospitals), changing to nursing homes, merging with other hospitals, inadequate insurance or no hospital insurance creating substantial losses, insurers better controlling their costs, and lower Medicare payments to rural hospitals.

Number of Employees Per Patient

Our review of the 34 cost reports covering the period prior to the fiscal year of hospital closing, and the 30 cost reports covering the fiscal year of hospital closing indicated that the number of employees per patient averaged 5.73 and 6.50 respectively, compared to the national average of 5.08 among all the rural hospitals. Compared to the 1985-1987 national average of \$2,615 cost per discharge, these closed hospitals averaged \$2,782 cost per discharge in the period prior to the fiscal year of closing, and \$3,472 in the fiscal year of closing.

CONCLUSIONS

Had the rural hospitals that closed in 1987 been reimbursed under urban Medicare payment rates instead of under rural rates, our analysis showed that on an overall basis, profitable hospitals would have increased from 7 to 15 in the period prior to the fiscal year of closing, but 19 hospitals would have remained unprofitable. In the year of closure, 3 hospitals would have been profitable under urban rate reimbursement compared against 27 (90 percent) that would have remained unprofitable. Medicare-profitable hospitals would have increased from 8 to 20 for the period prior to the fiscal year of closing, and from 3 to 8 for the fiscal year of closing.

Increasing the revenues by use of urban rates would have aided a few of the closed hospitals; however, our analysis of their overall and Medicare financial status showed that most of these hospitals suffered more from low utilization and subsequent higher costs per discharge caused by problems related to low occupancy, a low number of discharges, and a higher number of employees per patient. If the hospitals that closed for financial reasons could have significantly increased the number of patients admitted and discharged, or placed greater emphasis on controlling cost per discharge, these hospitals might have survived.

APPENDIX A

**PROFIT MARGINS FOR THE FISCAL
YEAR PRIOR TO HOSPITAL CLOSURE**

HOSPITAL	TOTAL HOSPITAL FINANCIAL DATA		MEDICARE INPATIENT FINANCIAL DATA	
	ACTUAL MARGINS(a)	SIMULATED MARGINS(b)	ACTUAL MARGINS(c)	SIMULATED MARGINS(d)
1	-2.12%	2.25%	24.52%	43.04%
2	-4.12%	19.37%	-13.88%	27.19%
3	27.56%	28.86%	-38.07%	-0.32%
4	12.20%	13.67%	-33.63%	-4.69%
5	-30.59%	-21.42%	-9.22%	27.38%
6	-20.71%	0.12%	-5.96%	22.50%
7	-106.99%	-96.87%	-18.02%	21.34%
8	-53.33%	-44.55%	-67.55%	-38.48%
9	-20.25%	-12.63%	38.61%	51.28%
10	9.14%	13.18%	-12.88%	15.24%
11	-136.12%	-112.82%	-58.36%	-23.28%
12	-18.07%	-7.32%	-71.44%	-27.17%
13	-9.11%	4.59%	4.18%	31.54%
14	-20.56%	-12.64%	-28.94%	-2.81%
15	-14.66%	-2.17%	-22.38%	4.18%
16	-14.72%	-12.03%	-59.46%	-10.07%
17	-1.11%	14.86%	-2.44%	29.73%
18	-41.42%	-29.20%	2.79%	20.05%
19	-3.58%	8.75%	-14.67%	15.44%
20	13.53%	18.20%	-33.24%	5.97%
21	-19.37%	-10.70%	3.41%	24.98%
22	-31.69%	-28.79%	-49.17%	-22.27%
23	-65.15%	-54.31%	-83.76%	-51.38%
24	-3.90%	1.84%	-115.66%	-69.97%
25	-30.53%	-15.78%	-35.57%	-10.00%
26	-9.80%	2.01%	10.15%	29.94%
27	16.03%	20.36%	-75.68%	-26.78%
28	-11.39%	-5.91%	-31.12%	-8.56%
29	-28.19%	-14.82%	-3.58%	15.42%
30	4.17%	5.74%	-56.18%	-25.34%
31	(e)	(e)	(e)	(e)
32	-9.90%	-0.46%	-20.59%	5.11%
33	1.56%	8.85%	6.43%	29.45%
34	-10.63%	-3.62%	-10.84%	15.66%
35	-6.03%	-2.75%	13.77%	31.56%
AVERAGE	-12.39%	-4.19%	-16.04%	11.95%

NOTES:

- (a) The actual margin is a percentage equivalent to the ratio computed by dividing the amount of profit or loss by amount of revenues. These financial data are reported to HCFA and maintained on the Hospital Cost Report Information System (HCRIS). The "total hospital" margins included revenues and costs of all patients, i.e. Medicare patients as well as non-Medicare patients. In addition, the "total hospital" data incorporates patient care and non-patient care activities.
- (b) The "simulated margins" were computed in our mathematical model. It shows the margin that would have resulted if the rural hospital had been paid for its Medicare patients as if it were an urban hospital. Our model did not change any non-Medicare data from that which was actually experienced by the rural hospital.
- (c) The Medicare "actual margins" are based upon the revenues and related costs of inpatient care furnished to Medicare patients.

In order to facilitate comparison with total hospital revenues and costs (which included the costs of medical education and capital), we computed total Medicare revenues and costs, including the pass-through costs of direct medical education, certified registered nursing anesthetists, and capital. This represented a change from our previous reports on Medicare profitability where we excluded the pass-through costs when computing the profit ratio on prospective payments. However, this change was necessary when comparing total Medicare costs to total hospital costs since it was not possible to obtain the amount of pass-through costs contained in the total hospital costs after allocation.

Therefore, in computing Medicare Part A inpatient operating revenues, we included DRG payments, outliers, pass-through costs reimbursements, indirect medical education payments, kidney acquisition costs reimbursements, return on equity payments and disproportionate share adjustment payments. We then reduced the total of these payments by the amounts of any applicable Congressionally-mandated sequestrations of Medicare revenues.

Medicare Part A inpatient operating costs included allocated amounts for routine, ancillary, specialized care, malpractice insurance and kidney acquisition costs, including pass-through costs. We calculated Medicare profit margins by dividing the difference between Medicare revenues and costs, by Medicare revenues. Any Medicare Part B revenues, Medicaid and other Federal program revenues are part of the hospitals' total revenues.

- (d) The Medicare inpatient "simulated margins" were computed from a mathematical model developed by OIG auditors. This model estimates the change (increase) in Medicare payments that would occur if the rural hospital had been located (and paid) at the nearest urban location. The increase in Medicare payment is the result of the interaction of two factors: (1) use of the urban standardized rate, and (2) use of the urban rather than the rural wage index. Our model does not change any other factors (such as case mix index) from that actually experienced by the rural hospital.
- (e) This hospital did not file a cost report for the fiscal year prior to its closing.

APPENDIX B

**PROFIT MARGINS FOR THE YEAR
DURING WHICH THE HOSPITAL CLOSED**

HOSPITAL	TOTAL HOSPITAL FINANCIAL DATA		MEDICARE INPATIENT FINANCIAL DATA	
	ACTUAL MARGINS (a)	SIMULATED MARGINS (a)	ACTUAL MARGINS (a)	SIMULATED MARGINS (a)
1	-77.56%	-70.77%	0.22%	23.38%
2	(b)	(b)	(b)	(b)
3	-433.78%	-395.45%	-48.47%	-4.89%
4	-15.73%	-15.38%	-244.92%	-194.76%
5	(c)	(c)	(c)	(c)
6	-24.63%	-8.93%	-57.81%	-21.60%
7	-36.83%	-33.69%	-223.42%	-155.36%
8	8.38%	13.22%	-43.88%	-14.74%
9	-44.53%	-39.78%	-22.97%	-8.45%
10	-24.28%	-20.07%	-20.06%	6.47%
11	-172.13%	-154.15%	-84.97%	-44.95%
12	-37.58%	-30.14%	-117.96%	-67.04%
13	(b)	(b)	(b)	(b)
14	-29.32%	-22.48%	-27.80%	-7.42%
15	-42.87%	-33.91%	-46.43%	-20.79%
16	(c)	(c)	(c)	(c)
17	-24.83%	-2.55%	-30.48%	9.53%
18	-142.31%	-110.90%	-34.25%	-11.23%
19	-5.65%	5.02%	-15.37%	11.31%
20	-7.25%	-2.84%	-76.11%	-30.10%
21	-2519.03%	-981.98%	-20.77%	4.91%
22	-113.60%	-112.31%	-256.96%	-205.48%
23	-452.88%	-374.62%	-52.74%	-19.34%
24	-42.52%	-39.74%	-487.75%	-382.25%
25	-47.70%	-33.92%	-48.42%	-21.06%
26	(c)	(c)	(c)	(c)
27	-160.14%	-145.59%	-84.13%	-29.77%
28	-15.65%	-11.03%	-40.09%	-18.03%
29	-17.33%	-5.94%	-10.05%	9.87%
30	-1095.04%	-994.98%	-174.95%	-127.15%
31	-107.67%	-78.62%	-46.52%	-15.72%
32	-60.53%	-50.30%	-74.75%	-47.41%
33	12.94%	17.53%	35.28%	48.83%
34	-6.82%	-2.37%	-27.08%	-0.89%
35	-8.60%	-5.94%	5.72%	22.22%
AVERAGE	-51.99%	-40.97%	-28.55%	-1.48%

NOTES:

- (a) The descriptions of the margin amounts are presented in Appendix A.
- (b) The hospital did not file a cost report during the fiscal period in which it closed.
- (c) Since some of the hospital's essential data appeared questionable and unreasonable, we did not include any of the hospital's data in our computations.

Chairman STARK. Our next witnesses constitute a panel. Molly McNulty, staff attorney with the National Health Law Program.

Mr. RETTIG. I would like to appear to in addition to the American Hospital Association witness. The senior vice president for legal affairs will give the testimony on dumping.

Chairman STARK. We will start with Ms. McNulty and your entire prepared testimony will appear in the record. You may enlighten us in any manner you are comfortable with.

STATEMENT OF MOLLY McNULTY, STAFF ATTORNEY, AND REV. SON FELLOW IN WOMEN'S LAW AND PUBLIC POLICY, NATIONAL HEALTH LAW PROGRAM

Ms. McNULTY. My name is Molly McNulty. I am staff attorney for the National Health Law Program.

My testimony is based on our experience in providing professional assistance to our indigent clients, and our extensive knowledge of the problems of access to health care, in particular the concerns our clients have raised with us about the subject of today's hearing—access to emergency room care.

Although we agree substantially with Mr. Kusserow's testimony, I am here to emphasize that Federal anti-patient-dumping status has substantially failed to stop patient dumpings. One-quarter of a million patients have been dumped annually over the last 3 years, and HHS has conducted only 281 investigations. Of those, only three hospitals have lost their Medicare contracts and only seven hospitals have been fined.

Why hasn't the statute worked? There are five causes that I will briefly discuss today. One, lack of notice; two, lack of recordkeeping; three, lack of reporting; four, vague definitions; and, five, and perhaps most important, ineffective private and agency enforcement.

First, notice: Basically, no one knows about the law. HCFA has given very little guidance to hospitals as to what the law requires. Most patients don't realize that they have a right to medical screening and treatment if they arrive in an unstable condition. Therefore, we recommend that the statute require written and posted notice, and we have State laws that so require attached to my written testimony.

Chairman STARK. Which States?

Ms. McNULTY. California, Tennessee, and I believe Louisiana.

The next point is recordkeeping. We have found that hospitals rarely keep records of transfers. In the States that now require records, those States have been more successful both at stopping patient dumping and enforcing the law.

Therefore, we recommend adoption of the recordkeeping requirement and have attached those State laws likewise to my written testimony.

Third, reporting: Even hospitals that are dumped upon rarely report those incidents to HHS. We recommend a statutory requirement to report dumping, and we feel this would help hospitals who feel political pressures locally not to report such incidents.

Four, definitions: Key terms such as emergency services, active labor, and stabilization are only vaguely defined in the statute and

proposed regulations. This makes it impossible for individual dumping victims to prove that they have been dumped. It also works a hardship on doctors and hospitals to know if they are actually complying with the law.

Therefore, we recommend adoption of statutory definitions that will be clearer and more comprehensive. We suggested definitions of the American College of Emergency Physicians and the Children's Defense Fund, and they are attached to our testimony.

Finally, I would like to stress that the legal standard of enforcement has worked a great hardship to stopping patient dumping. It is almost impossible, in these cases we have discussed, to meet the language required by the statute.

An individual dumping victim must show their injury was caused by the dump, even though a majority of these patients were obviously quite sick when they went to the emergency room and although they may have received medical care elsewhere.

The injury requirement undermines the original purpose of the statute, which was to prevent hospitals from transferring or discharging patients in dire medical need simply because they lack adequate insurance. Given the laxity of agency enforcement, private rights of action are the key to stopping patient dumping.

The statute creates a duty to medically screen and to treat unstable patients. If a hospital breaches this duty, they should be responsible. Therefore, we urge elimination of the injury requirement.

We also support Mr. Kusserow's written testimony urging elimination of the "knowingly standard" to impose civil money penalties on hospitals. As it stands now, both enforcement mechanisms, the private right of action, and agency enforcement, are ineffective because, on the one hand, it is impossible for individual victims to meet the standard and, on the other hand, it is impossible for the Government to enforce the standard.

To conclude, while we recognize the severe financial pressures that many hospitals face, and we believe that they are entitled to full reimbursement for their care, people are dying now. They do not deserve to die simply because they lack adequate insurance.

To achieve the original purpose of the statute, which was to halt needless suffering, illness, and death caused by patient dumping, the language of this law must be clarified and strengthened.

Thank you.

Chairman STARK. Thank you, Ms. McNulty, for an excellent testimony.

[The statement of Ms. McNulty follows:]

TESTIMONY OF MOLLY McNULTY
NATIONAL HEALTH LAW PROGRAM

Mr. Chairperson and Members of the Committee:

I appreciate your invitation to testify today on a matter of great importance to our clients.

The National Health Law Program is a health law support center funded by the Legal Services Corporation to provide professional advice and assistance to legal services advocates and their clients. We have extensive and ongoing contact with poor people and their representatives throughout the country regarding a variety of health care access issues.

My testimony is based on our experience in providing professional assistance to clients, and our extensive knowledge of the problems of access to health care, in particular the concerns our clients have raised with us about the subject of today's hearing, access to emergency room care.

This statement will present examples and statistics demonstrating that the federal anti-dumping statute, in its current form, has failed to achieve its purpose of preventing suffering, illness and death caused by denial of emergency services based on ability to pay ("patient dumping"). My testimony will also discuss some of the primary obstacles to the law's effectiveness, and will recommend specific statutory amendments to strengthen the law. The Appendix to my statement includes samples of successful state laws, and model statutory definitions.

A. Current Statute Has Failed To Stop Patient Dumping

Despite the passage of the federal anti-patient dumping statute almost three years ago, private and federal enforcement of the law has been ineffective in halting widespread practice of doctors and hospitals turning away emergency patients because of illegitimate or economic reasons.¹ The following two examples illustrate the problem:

1. Mrs. Trula Kerr, a 64 year old woman without medical insurance, became pale, incoherent, disoriented and shaky. The hospital to which her family took her told the family to send her home and to go to the free health clinic after the weekend.

The family was very concerned about their mother's condition. They did not believe she was well enough to go home. They took her to a second hospital where she was examined. She had extremely low blood sugar, double pneumonia, high blood pressure, and an enlarged heart. The doctor found that she was seriously unstable. Mrs. Kerr stayed in the hospital for about two weeks and died approximately two months later.

If the family had indeed followed the first hospital's orders, and had waited over the weekend to take her to a free clinic, Mrs. Kerr probably would have died immediately.

2. Another example comes from Fredericksburg, Virginia where a woman who was six and a half months pregnant

¹ Current Laws Don't Stop Patient Dumping, 18 The Chicago Reporter 9 (January 1989); Dumping The Poor: Despite Federal Law, Hospitals Still Reject Sick Who Can't Pay, Wall Street Journal, Page A1, November 29, 1988; Maternity Patient Dumping On The Rise, 2 HealthCare News (May 4, 1987); Strapped Inner-City Hospitals Dump Patients To Avoid Red Ink, 18 The Chicago Reporter (January 1989); Texas Leads Fight to Halt "Patient-Dumping" By Private Hospitals, The Washington Post A4, March 20, 1988 (transfers to public hospitals on the rise).

went to the local hospital when she began having labor pains and passing blood clots. Once at the hospital, the woman was told by a nurse that because she did not have a private doctor, nothing could be done for her. After a few hours she was told to go on her own to the university hospital which was a two hour drive away. The doctor on duty at the university hospital said that had a doctor treated her earlier, he could have arrested the premature delivery. However, because so much time elapsed, a premature baby was born that afternoon and died a few minutes after birth.

Statistics bear out the cases we have seen demonstrating the current weakness of the statute. Although estimates are that a quarter of a million illegal patient dumps occur annually², only 281 dumping cases had been investigated by the Health Care Financing Administration ("HCFA") as of March 31, 1989.³ Of these, only three hospitals lost their Medicare contracts. Two of those three hospitals have been reinstated. These extremely inadequate enforcement efforts of the Health Care Financing Administration demonstrate the need for strong, effective enforcement through individual private rights of action.

B. Primary Causes Of Ineffectiveness

My testimony will review some of the primary reasons why the anti-dumping statute has had only limited effectiveness. The primary cause is ineffective enforcement both by DHHS and private causes of action. Other causes include the lack of notice of the law to patients, doctors and hospitals; the failure to report dumping; and lack of record-keeping.

While some changes have been made in the proposed regulations⁴, the statute is three years old and there still are no final regulations to date. We therefore urge statutory changes to make this law enforceable and effective.

1. Lack Of Notice

One reason for the current statute's ineffectiveness is a lack of notice to patients, doctors, and hospitals that patient dumping is now illegal. Several states have gone beyond the federal anti-dumping law by requiring that hospitals inform patients of their rights to emergency room treatment, and/or that they inform hospital staff of their duty to provide emergency room treatment. For example, California now has an excellent provision requiring that a notice be posted to the public in each facility, and oral or written notice given to each emergency patient about their rights under this law. Their notice law requires that hospitals inform all emergency patients or their representatives of the reasons for the transfer, and of the patient's right to emergency services prior to transfer or discharges without regard to ability to pay. (See Appendix A for complete language).

² See Robert L. Schiff, M.D., David A. Answell, M.D., James E. Schlosser, et al., "Transfers to a Public Hospital: A Prospective Study of 467 Patients," *New England Journal of Medicine*, February 27, 1986; Equal Access to Health Care: Patient Dumping, Hearing before House of Representatives Committee on Government Operations (House Report 100-531) (March 25, 1988).

³ Telephone Conversation with Ms. Terry Harris, Survey and Certification Department, Health Care Financing Administration (May 10, 1989).

⁴ 53 Fed. Reg. 422513 (June 16, 1988).

2. Lack Of Record-Keeping

In addition, lack of record-keeping of transfers and discharges by hospitals makes violations of the statute virtually impossible to detect. States which currently require "Memoranda of Transfer" have been among the most successful at preventing patient dumps (See Appendix B for relevant statutes and regulations). For example, California now requires that a Memorandum of Transfer be completed and sent with each person who is transferred. This creates a record of all inappropriate transfers for the patients, and the hospitals that are dumped upon.

Texas' statute and regulations were used as a model for the federal statute. The Texas regulations require that detailed medical records and a "Memorandum of Transfer" must accompany each transferred patient. The Memorandum of Transfer tracks each transfer by requiring information on when permission to transfer the patient was received, when the transfer took place, and when the patient arrived at the receiving hospital. The Memorandum must be signed by transferring and receiving hospital physicians. The Memorandum is extremely helpful because it provides a mechanism for assessing whether the transfer was appropriate or, as critics charge is all too often the case, whether the patient was dumped. The Memorandum creates an enforcement mechanism by creating a uniform procedure among all hospitals, by educating the doctors about what they must do to comply with the law, and by creating a record that can be reviewed by state or federal authorities.

3. Hospital Failure To Report

A third cause of ineffectiveness is the failure of hospitals to report cases of patient dumping to the Department of Health and Human Services. The proposed regulations acknowledge the problem of unreported dumping incidents, and would require hospitals to report suspected incidents. However, the proposed regulations do not go far enough. The hospital itself will be able to claim it did not know of the incidents unless some procedure for assuring that the information is relayed to the appropriate people is put in place. Hospitals only know about incidents through their agents, who are the doctors. Therefore, doctors should be required to report incidents to the hospitals or to HCFA directly. Also, Peer Review Organizations (PROs), which are constantly reviewing hospital records as part of their responsibilities, must be required to report violations they learn about in the regular course of their work. The PROs are in an excellent position to learn about and report potential violations.

Further, more, a statutory reporting requirement really is necessary, a fact which has been brought to our attention by hospitals that are "dumped on." Some officials of such hospitals are very reluctant to complain about associate hospitals who violate the law. Certain hospitals that are seen as the facilities of last resort are the regular recipients of repeated inappropriate transfers. However, even though the law permits them to bring a private right of action against the violators, political pressures usually prevent them from bringing such actions. Hospitals that are receiving inappropriate transfers are often in the same association with the hospitals that do the dumping and therefore hesitate to complain about their associates' behavior. A change in the law which requires hospitals and physicians to report violations of the law to the appropriate authorities would remove political considerations and enforcement would be enhanced.

4. Obstacles To Enforcement

The core cause of the statute's current ineffectiveness is the difficulty of enforcement experienced by both DHS and by individual private causes of action.⁵ Enforcement is difficult (1) because the pertinent definitions are too vague, which makes enforcement difficult for DHS (OIG) and individual dumping victims; (2) because in order to impose civil money penalties the Office of the Inspector General must prove the doctor or hospital "knowingly" violated the law (the highest possible standard of proof) and (3) the requirement that individual dumping victims demonstrate that their injury was directly caused by the dump is often impossible -- thus denying victims compensation even when a doctor or hospital has violated the law.

A. Vague Definitions

The statute contains ambiguous definitions of key concepts that the proposed regulations do not clarify. Clarification of "emergency medical condition," "active labor," and "stabilization" are needed to help doctors and hospitals obey the anti-dumping law, and to help the federal government and individual dumping victims enforce the statute. The American College of Emergency Physicians (a national organization which sets standards for emergency room physicians) has clear and comprehensive definitions of "emergency medical condition" (Appendix C) and "to stabilize." (Appendix D). The Children's Defense Fund has proposed a clear definition of "active labor" (Appendix E) that will ensure adequate protection of women with obstetrical emergencies and their newborn babies. We endorse statutory adoption of these standards.

B. Self-Contradicting Liability Standards

A second obstacle to enforcement is that the "knowingly" standard as it applies to the imposition of civil money penalties by the Office of Inspector General. The Office of Inspector General must prove that the hospital "knowingly violated" the statute (the highest standard of proof). The "knowingly" requirement should be deleted from the statute for two reasons. First, the purpose of the statute is to require doctors/hospitals to medically screen emergency patients without first performing a "wallet biopsy," and to prevent transfer or discharge of patients in an unstable condition. When a doctor or hospital commits one of these illegal acts, they should be held liable. Adding an intent requirement to a dumping victim's burden of proof undermines the purpose and effectiveness of the statute.

C. Proof Of Direct Causation Undermines Statutory Purpose

A third problem with the enforcement provision for private rights of action is one of causation, proving that harm to an individual was directly caused by a hospital's illegal violation of the statute, and breach of its duty to screen and/or stabilize an emergency patient.

Most people who enter an emergency room are by definition sick or injured. Even if their conditions deteriorate or they die, it may not be possible to prove that harm was the direct result of the denial of care or patient transfer. Consider for example, the case of Terry Takevell, who was diabetic and very ill when he was denied treatment in the emergency room. Since necessary tests were never done, it would be extremely difficult to prove that the hospital's violation directly caused his death.

⁵ See, e.g., K. Rothenberg, Who Cares? Evolution of the Legal Duty To Provide Emergency Care, 36 Houston Law Review 21, 67 - 69 (1999); Dumping The Poor: Despite Federal Law, Hospitals Still Refuse Sick Who Can't Pay, Wall Street Journal, Page A1, November 9, 1988.

Furthermore, because he died, his direct testimony of what happened would not be available.

The language of H.R. 821, which would require a dumping victim to prove that she had been the "subject of a responsible physician's or a participating hospital's violation of a requirement of this section," more appropriately requires a plaintiff to prove that she was the subject of a negligent breach of the statutory duty to screen and/or stabilize an emergency patient. A higher standard of enforcement is unnecessary, since the purpose of the law is to halt transfers or discharges for illegitimate, economic reasons.

Private "attorneys general" (the dumping victims) should be encouraged to bring suits, not discouraged, for two reasons. First, we have seen the ineffectiveness of governmental enforcement to halt the widespread practice of patient dumping. Second, individual victims are often the only ones to know of dumping incidents, which are widely underreported. Evidence that a hospital dumped a patient in violation of the statute should be sufficient to prove harm. Otherwise, enforcement through private rights of action, the key to halting patient dumping, will be impossible.

D. "Good Faith Reliance" Gives Hospitals A Loophole

Finally, we oppose vigorously any amendment which would relieve a hospital of liability if it relies in good faith on a doctor's representation that a patient was not "dumped" for two reasons. First, this liability exception contradicts the current trend in hospital liability law. Second, an exception for hospitals also will render the statute meaningless because hospitals will never be liable for patient dumping.

Several legal doctrines recently have been used to hold a hospital liable for the negligent acts of physicians working on behalf of the hospital, such as emergency room physicians who screen and/or transfer patients. Respondent superior applies when a physician is a hospital employee.⁶ When a patient could reasonably have believed that an independent contractor physician was a hospital employee, the doctrine of apparent or ostensible agency may apply.⁷ When a hospital assumes a nondelegable duty, such as the provision of emergency services, the hospital is estopped (prevented) from isolating itself from physician negligence, even if the physician is an independent contractor (not a hospital employee).⁸

This legal trend recognizes that patients increasingly look to hospitals as institutions, not to individual doctors, for the provision of health care, particularly emergency services. Second, the law recognizes that an individual in the midst of a medical emergency has no meaningful choice about treatment; the individual in dire need of medical attention will quite literally take whatever is offered.

⁶ See, e.g., Bing v. Thunig, 2 N.Y.S. 2d 656, 143 N.E.2d 3, 163 N.Y.S. 2d 3 (1957).

⁷ See, e.g., Generis v. Hass, 45 Cal.2d 811, 291 P.2d 915 (1955); Brown v. Moore, 247 F.2d 711 (3rd Cir. 1957); Howard v. Park, 37 Mich. App. 495, 497, 195 N.W.2d 39, 40 (1972); Lundberg v. Bay View Hosp., 175 Ohio St. 133, 137, 191 N.E. 2d 821, 823 (1965); Adamski v. Tacoma General Hosp., 20 Wash. App. 98, 115, 579 P.2d 970, 978-79 (1978); Jackson v. Power, 743 P.2d 1376 (Alaska 1987).

⁸ See, e.g., Griffin v. Mathews, 36 Ohio App. 3d 228; Jackson v. Power, 743 P.2d 1376 (Alaska 1987).

The trend toward hospital liability for the negligent acts of its physicians (whether employees or independent contractors), is exemplified by a 1987 case, Jackson v. Pover,⁹ which viewed the provision of emergency services as an inherent function of the hospital and states: "a hospital . . . may not shield itself from liability by claiming that it is not responsible for the results of negligently performed health care when the law imposes a duty on a hospital to provide that health care."¹⁰ Essentially, Jackson recognized that "The hospital as an institution bears the ultimate responsibility for complying with the mandates of the law...."¹¹

CONCLUSION

The statute's effectiveness would be dramatically improved by requiring notice, recordkeeping and reporting; and by promoting enforcement by dumping victims and by DHHS. Therefore, we believe the Stark amendments are necessary to protect the health of indigent or uninsured people in this country, and we urge strengthening of the proposed amendment by including reporting requirements and specific definitions of terms.

⁹ 743 P.2d 1376 (Alaska, 1987).

¹⁰ Id. at 1384.

¹¹ Jackson v. Pover, 743 P.2d at 1384.

Appendices
to
Testimony of National Health Law Program

1. Sample State Emergency Room Law Requiring Notice to Patients or Staff
2. Sample State "Memorandum of Transfer" Requirements
3. Model Definition of "Medical Emergency"
4. Model Definition of "Stabilization"
5. Model Definition of "Active Labor"

APPENDIX ASample State Emergency Room Law Requiring Notice to Patients or Staff

California Cal. Health & Safety Code § 1317.3(d).

(d) A condition of licensure, all hospitals shall inform all persons presented to an emergency room or their representatives if any are present and the person is unable to understand verbal or written communication, both orally and in writing, of the reasons for the transfer or refusal to provide emergency services and care and of the person's right to emergency services and care prior to transfer or discharge without regard to ability to pay. Nothing in this subdivision requires notification of the reasons for the transfer in advance of the transfer where a person is unaccompanied and the hospital has made a reasonable effort to locate a representative, and because of the person's physical or mental condition, notification is not possible. All hospitals shall prominently post a sign in their emergency rooms informing the public of their rights. Both the posted sign and written communication concerning the transfer or refusal to provide emergency services and care shall give the address of the department as the government agency to contact in the event the person wishes to complain about the hospital's conduct.

Tennessee Tenn. Comp. R. & Regs. §§ 1200-8-5.02.

If a patient has not or cannot be stabilized, the patient can request a transfer after she or he has been given complete and accurate information about (1) the medical necessity for the movement, (2) the availability of appropriate medical services at both the transferring and receiving hospitals, and (3) the availability of indigent care programs at the hospital initiating the transfer:

Reaching the Transfer Decision

If a patient at a hospital has not been or cannot be stabilized within the meaning of Section 1200-8-5-.01(5), the hospital may not transfer the patient unless:

- (a) (1) The patient (or a legally responsible person acting on the patient's behalf) requests that the transfer be effected, after having been complete and accurate information about matters material to the transfer decision, including, if feasible:
 - (a) the medical necessity for the movement;
 - (b) the availability of appropriate medical services at both the transferring and receiving hospitals; and
 - (c) the availability at the hospital initiating the transfer of indigent care and the facility's legal obligations, if any, to provide medical services without regard to the patient's ability to pay; and the hospital's participation in medical assistance programs of the federal, state or local government, and, if participating, any obligation to accept the medical assistance programs' reimbursement as payment in full for the needed medical care.

APPENDIX B

Sample State "Memorandum of Transfer" Requirements

CALIFORNIA

Cal. Health & Safety Code § 1317.2

(f) The records transferred with the person include a "Transfer Summary" signed by the transferring physician and surgeon which contains relevant transfer information. The form of the "Transfer Summary" shall, at a minimum, contain the person's name, address, sex, race, age, insurance status, and medical condition; the name and address of the transferring physician and surgeon or emergency department personnel authorizing the transfer; the time and date the person was first presented at the transferring hospital; the name of the physician and surgeon at the receiving hospital consenting to the transfer and the time and date of the consent; the time and date of the transfer; the reason for the transfer; and the declaration of the signor that the signor is assured, within reasonable medical probability, that the transfer creates no medical hazard to the patient. Neither the transferring physician and surgeon nor transferring hospital shall be required to duplicate, in the "Transfer Summary," information contained in medical records transferred with the person.

TEXAS

Hospital Licensing Regulations § 133.21 (1985).

11-2.10. Memorandum of Transfer.

The hospital's policy shall provide that a memorandum of transfer be completed for every patient who is transferred.

The form and content of the memorandum of transfer shall be prescribed by the director.

The memorandum shall contain the following information:

- the patient's full name, if known;
 - the patient's address and next of kin, if known;
 - the name, telephone number and address of both the transferring and receiving physicians;
 - the name and address of both the transferring and receiving hospitals;
 - the time and date on which the patient first presented or was presented to the transferring physician and transferring hospital;
 - the time and date on which the transferring physician secured a receiving physician;
 - the time and date on which the actual patient transfer was undertaken;
 - the time and date on which the receiving physician assumed responsibility for the patient; and
 - the time and date on which the patient was admitted to the receiving hospital;
- The memorandum of transfer shall be signed by the transferring physician or a hospital staff member

acting under the physician's orders pursuant to 11-2.2.4 and 11-2.2.5 of this chapter and hospital administration.

The receipt of the memorandum of transfer shall be acknowledged in writing by both the receiving hospital administration and physician.

A copy of the memorandum of transfer shall be retained by both the transferring and receiving hospitals. The memorandum shall be filed separately from the patient's medical record and in a manner which will facilitate its inspection by the division.

APPENDIX C**Model Definition of "Medical Emergency"**

According to the American College of Emergency Physicians, a medical emergency includes:

- 1) Any acute condition resulting in admission of the patient to a hospital or nursing home within 24 hours;
- 2) Evaluation or repair of acute (less than 72 hours) trauma;
- 3) Relief of acute or severe pain;
- 4) Investigation or relief of acute infection;
- 5) Protection of public health;
- 6) Obstetrical crises and/or labor;
- 7) Hemorrhage or threat of hemorrhage;
- 8) Shock or impending shock;
- 9) Investigation and management of suspected abuse or neglect of person which, if not interrupted, could result in temporary or permanent physical or psychological harm;
- 10) Congenital defects or abnormalities in a newborn infant best managed by prompt intervention;
- 11) Decompensation or threat of decompensation of vital functions, such as sensorium [sic], respiration, circulation, excretion, mobility, or sensory organs;
- 12) Management of a patient suspected to be suffering from a mental illness and posing an apparent danger to the safety of himself, herself or others; or
- 13) Any sudden and/or serious symptom(s) which might indicate a condition which constitutes a threat to the patient's physical or psychological well-being requiring immediate medical attention to prevent possible deterioration, disability or death.

APPENDIX D

Model Definition of "Stabilization"

Stabilization includes adequate evaluation and initiation of treatment to assure that transfer of a patient will not, within reasonable medical probability, result in death or loss or serious impairment of bodily functions, parts, or organs.

Evaluation and treatment of patients prior to transfer should include the following:

- 1) Establishing and assuring an adequate airway and adequate ventilation;
- 2) Initiating control of hemorrhage;
- 3) Stabilizing and splinting the spine or fractures when indicated;
- 4) Establishing and maintaining adequate access routes for fluid administration;
- 5) Initiating adequate fluid and/or blood replacement; and
- 6) Determining that the patient's vital signs (including blood pressure, pulse, respiration, and urinary output, if indicated) are sufficient to sustain adequate perfusion. The vital signs should remain within these parameters for a sufficient time prior to transfer in order that the physician may be reasonably certain that they will not deteriorate while the patient is en route to the receiving hospital.

There may be times, however, when stabilization of a patient's vital signs is not possible because the hospital or emergency department does not have the appropriate personnel or equipment needed to correct the underlying process (e.g., thoracic surgeon on staff & cardiopulmonary bypass capability). In these cases, steps 1-5 should be performed and transfer should be carried out as quickly as possible.

American College of Emergency Physicians, The Guidelines for Transfers of Patients (14 Annals Emerg. Med. 1221, 1221 (1985))

APPENDIX E**Model Definition of "Active Labor"****Specified Emergency Perinatal Conditions Requiring Immediate Hospital Admission**

1. Threatened prematurity or preterm labor
 - a) less than 37 weeks gestation and
 - b) regular contractions without reference to intervals and without evidence of dilation or effacement.

Rationale: Immediate hospitalization would be warranted to attempt arrest of preterm labor or else insure delivery of the infant in an appropriate setting. Failure to admit could result in delivery and subsequent fetal death during stabilization and transport of the very small infant. Hospitalization might avert this type of delivery and prevent it. The financial consequences of a preterm labor can be extremely high. Prolonging the pregnancy in utero, even considering the cost of hospitalization and monitoring of the mother, is considerably less expensive than neonatal intensive care.

2. Hemorrhaging (presence of clots)
 - a) after the first trimester and accompanied by at least one of the following:
 - 1) contractions
 - 2) manifestation of pain
 - 3) abruptio or low lying placenta
 - 4) change in vital signs consistent with hypovolemia

Rationale: Immediate hospitalization is warranted because of the high maternal mortality that results from hemorrhage.

3. Non-diet-controlled diabetes
 - a) either gestational or underlying class A or B diabetes or
 - b) physician certifies that inpatient management is necessary to preserve health of mother and/or infant and/or to prevent preterm labor.

Rationale: Hospitalization is generally accepted early in pregnancy for control of diabetes through very strict glucose monitoring. Diabetes late in pregnancy is associated with macrosomia and very large birthweight which frequently makes delivery of the infant difficult or impossible. Neonatal hypoglycemia is very common in the newborns of diabetics of all classes, and the newborn needs monitoring in a nursery equipped for, and with an understanding of, such care.

4. Preeclampsia or eclampsia
 - a) symptoms may include edema severity beyond normal levels, hyperreflexia, proteinuria, hypertension or seizures
 - b) physician certifies degree and severity to warrant inpatient management to preserve health of mother and/or infant.

Rationale: In some areas of the country, preeclampsia and eclampsia constitute the single greatest cause of maternal death and mortality. Expert care and nursing service needs require that all such patients be hospitalized both antepartum and during labor and delivery process. Failure to control preeclampsia in a hospital setting may well lead to death of the mother and loss of the infant.

5. Caesarean section
 - a) prior to labor in cases including prior classical Caesarian section, or

- b) prior to labor in cases including herpes if active lesions are present, or
- c) prior to labor in cases of post term gestation of 41 weeks
- d) after onset of labor as medically necessary.

Rationale: All Caesarean sections must be performed in a hospital setting, regardless of the reason for the section. The section is often needed prior to the onset of active labor.

- 6. Chronic maternal diseases necessitating immediate hospitalization to reduce maternal and/or infant mortality or morbidity. Examples include:
 - a) prosthetic heart valves requiring anticoagulant therapy
 - b) poorly controlled endocrine conditions
 - c) chronic hypertension

Rationale: Any chronic maternal disease that threatens the life of both the mother and infant must be treated in a hospital setting.

- 7. Fetal cardiac problem detected prior to labor and delivery (e.g., transportation of vessels).

Rationale: Once a fetal cardiac problem is detected, hospitalization for further monitoring and eventual delivery are essential. There is a high degree of fetal mortality if delivery is not in a setting where such problems can be quickly diagnosed and corrected.

- 8. Presence of spinal cord defects detected through ultrasound and/or amniocentesis.

Rationale: This condition can result in both fetal mortality and morbidity. A level of care with anesthetic capabilities and pediatric surgical specialists should be available where these patients are transferred and delivered.

- 9. Hydrocephalus detected (prior to onset of labor)

Rationale: This condition can result in both fetal mortality and pediatric surgical specialists should be available where these patients are transferred and delivered.

- 10. Fetal monitor labor-related problems showing evidence of fetal compromise, such as fetal bradycardia.

Rationale: When labor-related problems are detected prior to delivery, hospitalization is vital to assure delivery in an appropriate setting able to treat and care for such complications.

- 11. Breech position

Rationale: Abnormal presentations require a level of care only obstetricians and gynecologists can provide within a hospital setting. Failure to receive proper care can result in both maternal and infant death.

- 12. Limbs protruding

Rationale: Abnormal presentations require a level of care only obstetricians and gynecologists can provide within a hospital setting. Failure to receive proper care can result in both maternal and infant death.

- 13. Very low birthweight (detected prior to labor and delivery)

Rationale: All infants detected as very low birthweight prior to birth should be delivered in level II or III hospitals so

Medical problems related to small size can be treated. No such infants should be delivered outside a hospital setting. Even a delivery in a level I hospital increases the likelihood of appropriate transfer. Delivery in a level II or III hospital ensures that care by a neonatologist and extensive intensive care units for low birthweight babies are available. Long term economic benefits are significant due to savings in later hospitalizations.

14. Prolonged rupture of the membrane (more than 24 hours) prior to the onset of active labor

Rationale: Prolonged rupture of the membranes is a strong indicator of sepsis or other complications. Delivery should be induced as expeditiously as possible whenever sepsis is either present or likely. Induced labor cannot be done on an outpatient basis.

15. Maternal fever with or without rupture.

Rationale: Maternal fever requires careful monitoring and observation in a hospital setting to identify the source of fever and treat if appropriate. Failure to do so could cause infant mortality or morbidity.

16. History of metabolic problems in other children (prior to or after birth)

Rationale: All infants of mothers whose other children have a history of metabolic problems should be delivered in a hospital setting. The high risk of metabolic problems in such infants requires monitoring in a nursery equipped for and with an understanding of care for potential problems.

17. Active labor (adopt American College of Emergency Physicians standards). In the case of women giving birth for the first time: regular contractions at approximately 5-minute intervals. In the case of women who have given birth previously: as soon as contractions are regular and a diagnosis of labor is made.

18. Presence of maternal risk factors prior to "active" labor that could threaten maternal and/or infant mortality and/or morbidity such as:

- a) multiple gestations
- b) grand multiparous (greater than 5 pregnancies)
- c) maternal age (under 15 or under 35)
- d) no prior prenatal care

Rationale: Maternal risk factors such as multiple gestations, grand multiparous, maternal age, or a lack of prior prenatal care place the infant at a very high risk of prematurity and low birthweight and the mother in jeopardy of hemorrhage or other complications. Consequently, antepartum care and delivery should be accomplished in a close hospitalization setting.

19. Any condition which physicians certify requires an immediate admission in order to sustain the mother's or infant's life, to prevent serious permanent disfigurement, or loss or impairment of a bodily member or organ.

Chairman STARK. Mr. Anthony.

**STATEMENT OF MICHAEL ANTHONY, SENIOR VICE PRESIDENT,
OFFICE OF LEGAL AND REGULATORY AFFAIRS, AMERICAN
HOSPITAL ASSOCIATION**

Mr. MICHAEL ANTHONY. Well, Mr. Chairman, committee members, I, first of all, appreciate the opportunity to testify on behalf of our hospitals, and like those who have gone before us today, we believe what is called patient dumping is inexcusable and intolerable.

We recognize that those truly in need of urgent care need to have that care provided, and we also know that dumping compromises the integrity of health care providers, both hospitals and physicians.

For these reasons, we have spent a lot of time and effort trying to communicate to our hospitals the importance of understanding the new law and the obligations to treat and transfer patients appropriately and once the final regulations are out, we do intend to communicate once again regarding compliance with the final regulations.

Turning to the proposed legislation, we generally support H.R. 821, especially the clarifications it brings to the existing law. Many of those clarifications we mentioned in our comments on the regulations, and we also support the idea of holding hospitals responsible for those activities that are squarely within their control.

Talking for a moment about what is within the hospital's control, we believe that all hospitals should have in place a policy against such transfers coupled with an ethos of competent medical care.

They should have peer review in place, they should be vigilant in reviewing medical staff applications, and they should have protocols for the type of informed consent discussed in the bill, as well as effecting transfers and receiving transfers.

But the hospitals in many cases have to rely on the medical judgment of the physicians in their emergency room, and the courts over time have helped us determine what that line is as to what hospitals can do and what they can't do in terms of physician medical judgment in the emergency room.

We set forth in our testimony that we would like to work with your staff in defining what a hospital can do and what responsibility it should take for actions in the emergency room and whether it has to realistically rely on the medical judgment of physicians in the emergency room.

For example, in a hospital emergency room if there appears a nonemployed physician—when I say nonemployed, I mean someone who is not paid directly by the hospital, but is on staff—who determines that a patient is stable, they make the medical determination that the patient is stable, and that patient is then transferred, that would be a violation of the act. I have to ask you if it would be responsible to hold the hospital in a position where they would have violated the act because of that medical judgment, should they be terminated from the program because they relied on a physician's medical judgment?

H.R. 5468, which Representative Stark introduced during the 100th Congress, addressed this problem, and we felt that it was dealt with very effectively in that bill. We also believe that the civil money penalties and exclusionary powers of the Secretary and the inspector general are both deterrents to dumping.

They should have flexibility to use either sanction as appropriate rather than automatically applying termination or suspension from Medicare. We believe that there should be some flexibility there and the termination should not be automatic.

We would also like to work to ensure that the proposed Federal cause of action, which can be brought by any patient for any violation, whether it is a technical violation or a serious violation, even if the patient isn't harmed, doesn't eliminate the positive effects of State tort reform efforts.

This new Federal cause of action, in essence, sets up a new action that will have a new body of law surrounding it, and that new body of law and those decisions regarding that cause of action need not respect State tort reform initiatives that have been debated at the State levels and put in place to effectively protect access to care.

On a final front, we would like to work with the Secretary in defining a comprehensive list of services and facilities which must accept transfers and also in designing an appropriate informed consent methodology.

Thank you, Mr. Chairman.

[The statement of Mr. Michael Anthony follows:]

American Hospital Association



Capital Place, Building #3
50 F Street, N.W.
Suite 1100
Washington, D.C. 20001
Telephone 202/638-1100
Cable Address: Amerhosp

Statement
of the
American Hospital Association
before the Subcommittee on Health
of the
Committee on Ways and Means
of the
United States House of Representatives
on the
Medicare Hospital Patient Protection Amendments of 1989 (H.R. 821)

May 15, 1989

SUMMARY

The issue of inappropriate transfers of medically indigent patients has received much publicity in the press and has rightly been the subject of congressional concern. Even a single episode of patient "dumping" is intolerable. However, laws enacted to address this problem must be carefully crafted so as not to hinder the provision of urgently needed services. Seriously ill or injured patients often require transfer to a hospital with specialized emergency capabilities able to provide necessary care.

H.R.821 would, in part, clarify existing law. It would also impose additional responsibilities on hospitals and extend the basis for civil liability. The effect of H.R.821's requirements on hospital operations, and its impact on state initiatives designed to ameliorate inadequate access to medical care, must be considered.

INTRODUCTION

Mr. Chairman, I am Michael Anthony, Senior Vice President for Legal Affairs of the American Hospital Association (AHA). I appreciate this opportunity to appear before you today on behalf of the AHA and its nearly 5,500 member hospitals.

Background

The issue that you are addressing today -- inappropriate transfers of medically indigent patients, commonly referred to as patient "dumping" -- deserves serious attention. Let me state at the outset that it is the position of the AMA that patient dumping is inexcusable and intolerable. Dumping of individuals truly in need of urgent care endangers these people and compromises the integrity of all health care providers and institutions.

The AMA has taken an active role in informing its members of their obligations to treat and transfer patients appropriately. Articles generated by AMA staff have appeared in various AMA publications, including AMA News, Health Law Vigil and (awaiting publication) the Journal of Health and Hospital Law, concerning these obligations. Further, an AMA-sponsored editorial condemning dumping was published in U.S.A. Today, and AMA President Carol McCarthy appeared on the MacNeil-Lehrer News Hour condemning this practice. Once final regulations are issued, the AMA will dedicate a mailing to its members discussing the mechanics of compliance. We have not taken lightly our responsibility to work toward the elimination of patient dumping.

At the same time, legislation directed toward this problem must be carefully designed so as to not hamper necessary medical care. Hospitals' intent is that each transfer be in the patient's best interest, and, in fact, the vast majority are. Transfers from small, local hospitals to more sophisticated facilities meet this criterion. Any severely burned child should be treated promptly in a burn center, while accident victims may have the best chance of survival when treated by trauma specialists. Not all hospitals are able to provide such services. Any legislative proposal must take such appropriate transfers into account and assure that individuals are not denied needed care because of difficulty complying with law. The law also should not interfere with efforts at the state level that effectively address medical care delivery issues.

We generally support H.R.821, which in part serves to clarify existing law. The additional obligations that it imposes, such as the obligation to secure informed consent and the obligation to accept patients requiring specialized emergency services, largely codify policies that most hospitals have already adopted. Enforcement efforts that recognize the respective roles of hospitals and physicians in treating emergency patients also seem appropriate.

We do believe, however, that the frantic pace of emergency room care requires special sensitivity to any burdens that are placed on hospitals. Further, we believe that the scope of H.R.821 should be expanded to rectify certain problems with current law.

Agency Liability

The statutory prohibition against inappropriate transfers is set forth in section 1867 of the Social Security Act (42 USC §1395dd). H.R.821 would amend section 1867 to provide that "a hospital shall be liable...for the acts and omissions of its agents, and the physicians through whom it carries out its duties under [section 1867]." In fact, we have always interpreted current law to hold hospitals responsible for "knowing and willful, or negligent" violations of section 1867. H.R.821, however, in its well-intentioned attempt to clarify this provision, would hold hospitals responsible for actions wholly beyond their control. We believe that this imposes an unfair burden on hospitals, holding them responsible for actions that they are helpless to prevent.

Courts have crafted a reasonable standard of care that must be exercised by hospitals in their relationships with physicians who are neither employed by nor controlled by hospitals in rendering medical judgment. This standard holds hospitals responsible for care rendered by members of their medical staffs in three types of situations: (1) where an employee or agent is fully or partially responsible for the negligent care provided to a patient; (2) where the hospital negligently granted privileges to a member of its medical staff; and (3) where the hospital knew or should have known that a member of its medical staff was providing inappropriate medical care by virtue of an existing pattern of substandard care. Case law has explicitly recognized, therefore, that a careful delineation of hospital and physician responsibilities must be made before apportioning liability. Hospitals are only held responsible for failing to meet the standard of care required of them. H.R.821 should be changed to respect this well-reasoned body of law.

-3-

Hospitals must act to prevent inappropriate patient transfers. A strong policy against inappropriate patient transfers, coupled with an ethos of providing competent medical care; careful screening of medical staff applicants; thorough, vigilant peer review; and a protocol for obtaining informed consent and effecting transfer, are all that hospitals can reasonably be expected to do to assure that inappropriate transfers do not occur. By law, hospitals must, barring reason to believe otherwise, rely on the sound medical judgment of their medical staffs. In instances when a hospital has appropriate policies in place to prevent patient dumping, it is inappropriate to hold the hospital responsible if a non-employee physician wrongfully fails to screen or treat a patient, or transfers a patient.

H.R. 5468, a bill on patient dumping introduced by Representative Stark during the 100th Congress, recognized that there are situations when hospitals cannot, and should not, be responsible for the independent actions of their medical staffs. While it would have held hospitals generally responsible for the acts and omissions of their agents and the members of their medical staffs, it also provided that:

....a hospital shall not be liable if it reasonably relies in good faith on the medical judgment of such a physician with respect to--

- (A) a certification [that a transfer is appropriate] under subsection (c)(1)(A),
- (B) a determination that an individual does not have an emergency medical condition or is not in active labor, or
- (C) a determination that an individual has been stabilized (emphasis added).

We believe that this approach strikes the proper balance between holding a hospital responsible for actions under its control and recognizing that certain obligations, which depend on medical judgment, must be delegated to independent actors. We therefore urge that H.R. 821 be amended to adopt the "exceptions" language contained in its predecessor. If a hospital fails to intervene as an abusive pattern of medical judgment emerges, it should lose protection, as is now demonstrable in the line of court cases that interpret agency theory in the hospital/physician context.

Civil Money Penalties

The Secretary currently has two enforcement mechanisms for violations of section 1867: termination of the provider agreement, or suspension from the Medicare program. Proposed regulations issued June 16, 1988 (53 Fed. Reg. 22513-22527), would require that a hospital that negligently or knowingly and willfully violates section 1867 be terminated from the Medicare program on 48 hours notice. In addition, a civil money penalty may be imposed.

Any violation of section 1867 is wrong. Nevertheless, technical violations of the law may occur which, while not resulting in harm to a patient, would, under the statute and proposed regulations, mandate termination or suspension from the Medicare program. Further, even in the terrible situation when a patient is harmed, termination would likely be inappropriate when a hospital has not acted knowingly and willfully in arranging for transfer and has taken corrective action to assure that further violations do not occur.

Mr. Chairman, we believe that H.R. 821 should address the situation in which a hospital is terminated from the Medicare program, and a community is thereby denied needed hospital services, because of an isolated violation of section 1867. H.R. 821 should amend the law to provide that civil money penalties may be imposed in lieu of automatic termination or suspension. Termination or suspension should apply in egregious situations, such as when a pattern of negligent, inappropriate transfers is discerned or the hospital knowingly and willfully participates in a violation. In other instances, the Secretary should have the freedom to impose a lesser sanction if appropriate.

-4-

Civil Enforcement

Section 1867 authorizes patients, who have suffered harm as a result of a violation of the law, to bring a civil action against the hospital and to obtain damages available for personal injury under state law. H.R.821 would amend this provision to permit an individual to bring a civil action against a physician who violates the law as well. Proof of harm resulting from a violation of the law would no longer be required. Minimum damages of \$25,000 would be established, rather than tying damages to the amount available under state law. Reliance on state law for the parameters of damage determinations is also not required.

While this provision in H.R.821 has the laudable goal of extending and facilitating enforcement actions, we believe that it will create more problems than it solves. By removing section 1867's statutory mandate to predicate damage determinations on state law, H.R.821 will create a new, federal cause of action that will be used to skirt state tort reform initiatives. These reform initiatives were adopted to address state-specific episodes of inadequate access to care resulting from escalating malpractice premiums.

The situation that arose in Florida is but one example of the need to respect State tort reform efforts. There, obstetrician/gynecologists and emergency room physicians declined to treat emergency patients because of prohibitive malpractice premiums required for these activities. Hospitals were forced to close emergency services, and patients were exposed to great danger when seeking an available facility. Only by calling a special legislative session on the availability of malpractice insurance, and enacting laws to address the problem, was Florida able to avert this crisis. Removing section 1867's grounding in state law could result in a return to these unworkable situations. We urge, therefore, that civil damages under section 1867 continue to be determined under state law.

We also believe that H.R.821 should not remove the requirement that an individual demonstrate harm resulting from a violation in order to receive civil damages. The purpose of civil suits is to provide compensation for injury. By removing the harm requirement, H.R.821 changes civil actions from a compensatory vehicle to a quasi-criminal vehicle, i.e., punishment for every (even technical) violation of the law.

For example, is it appropriate that a hospital be subjected to loss of participation in government programs, significant civil money penalties, and a minimum of \$25,000 in civil damages with no constraints available under state tort reform initiatives, when no harm results to the patient and the violation at issue involves failure fully to advise a patient of the risks and benefits of an otherwise appropriate transfer? Can a hospital be vigilant enough and become so involved in the exercise of medical judgment to prevent such isolated incidents? We see no need to invite individuals to challenge retrospectively treatment or transfer decisions that result in no harm. If harm results, a patient may seek redress through state courts under well articulated medical liability theories.

Nondiscrimination

H.R.821 would require that a "hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units, (with respect to rural areas) regional referral centers as identified by the Secretary in regulation) shall not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities [sic] the hospital has the capacity to treat the individual."

We support this amendment. Instances of what has come to be referred to as "reverse patient dumping" should be addressed. Further, we believe that H.R.821 properly recognizes that the capacity to accept additional patients must also be present.

-5-

We suggest, however, that, for clarity, H.R.821 require the Secretary to develop a comprehensive list of those services and facilities that must accept transfers, subject to the capacity to do so. Such a listing should not include those services, such as experimental procedures, where access is not generally available to all individuals.

Informed Consent

H.R.821 imposes a requirement of informed consent upon treatment and transfer decisions. This requirement is appropriate. There is a need to ensure the appropriate treatment information is being conveyed to hospital patients. Nevertheless, while we support the need for an informed consent process, we are concerned about the implementation of this requirement as established in H.R.821.

An informed consent requirement that mandates a detailed, fact-specific listing of the benefits and risks associated with the transfer of a patient could cause harmful delay in providing critically necessary medical care. Transcriptionists are not available in an emergency room. Physicians must be allowed to convey information to patients, and to secure their informed consent, in a manner that does not interfere with the delivery of necessary care. The American Society for Healthcare Risk Management, a personal membership group of the AMA, in conjunction with the American College of Emergency Physicians, is exploring the development of a model form that may be adopted for this purpose. I urge the Committee to consider this and any other efforts directed toward making informed consent workable in the emergency room context.

The parameters of informed consent, which are governed by varying state laws, must also be carefully considered, so that H.R.821 takes into account these laws and any delay that may result in the provision of necessary care due to compliance. For example, H.R.821 would require a physician to instruct the patient concerning the risks and benefits of treatment and transfer. We believe that this requirement should be restricted to material risks, as generally required by common law.

Conclusion

Mr. Chairman, I would like to reiterate AMA's support for legislation that addresses the problem of inappropriate patient transfers. AMA would be happy to assist you in the further development of this legislation.

Chairman STARK. Thank you.

Are you going to add something to this, Paul, or are you just going to referee?

Mr. RETTIG. I am only here to assist in answering any of the committee's questions.

Chairman STARK. Thank you.

I have been getting a crash course in torts here from my colleague, Mr. Levin. I have always thought a tort was something you put fruit in, but I gather that the major difference here is this knowing or should have known, and my instincts are that any doctor sure as well should have known.

I mean, that is what you license doctors to know. Should they transfer this person or not I guess I would like the witnesses to kind of take me out of the issue of all this tort mumbo-jumbo and say what really goes on in the emergency room that a doctor knew or should have known.

I mean, how does this come down practically? We all agree we don't want hospitals to dump patients. One of the good ways to get them not to dump is to put them in jail if they do.

Now, that tends to get people's interest.

But the point is what is the difference? Ms. McNulty, can you put those differences in layperson's terms?

Ms. McNULTY. Well, if I understand your question correctly, you are asking what differences between State malpractice and the "knowingly standard" currently in the statute?

Chairman STARK. Somebody wants us to strike knowingly violated and to say violated.

Ms. McNULTY. Well, in fact, that relates more to the inspector general's cause of action than ours, but I can explain briefly that the current requirement is that HHS, in order to impose civil money penalties on a hospital, has to prove that the hospital knowingly violated the law.

The objection to that is that this is an extremely difficult standard of proof to meet and, in fact, is higher than even some criminal laws which require only that the party intended to commit the act, not that they intended to violate the law.

Chairman STARK. Let me see—so what you are saying is that if somebody comes in and they appear to be in some kind of shock or they are having difficulty breathing, but they look very poor so the hospital says, onto the next hospital with you, we don't have time for you, and it turns out that this person was in some kind of asthmatic shock or something, and the hospital will say we didn't know that, we didn't have time to treat him and we sent him on.

My concern would be that they should have known, they should have taken the trouble to find out why a person was wheezing or convulsing or bleeding.

Ms. McNULTY. Right.

Chairman STARK. I mean, that is why you go to hospitals, and that they should have even a lower standard is what you are suggesting, and I think I agree with you, then proving that to someone else.

I don't think Mr. Anthony is going to agree with that.

Mr. MICHAEL ANTHONY. What you are talking now about is willful, knowing, and negligent actions, and they are being struck from

the bill in H.R. 821. If you eliminate all of those, you have a strict liability. The hospital or the doctor is responsible for any violation.

Chairman STARK. Aren't they responsible now generally for any malpractice?

We don't sue anyone else for malpractice, do we, besides the hospital or the doctor? If they cut off the wrong leg, it was either the hospital who had the person on his stomach instead of his back or it was the doctor who couldn't tell right from left, so we just go after one of those two, right?

Mr. MICHAEL ANTHONY. Most typically. Sometimes there are others who are brought in as defendants as well. On the issue of negligence, what we are saying here is that there are certain circumstances when a hospital can be there to intercede in a patient-physician encounter, and in other cases when they cannot, especially in an emergency setting.

Many emergency rooms and hospitals, the hospitals do actually employ the doctors, but they are very much in the minority. In other cases, there are staff physicians who come in and handle the work in the emergency room or there are independent contractors, and the hospital personnel working in the emergency room cannot always be there to monitor the interaction to the point where they could intercede and override a decision by a physician as to whether the patient is stable, whether this is an emergency situation or whether this patient is in active labor.

What we are saying here is they will be held responsible.

Chairman STARK. What is the other side of that, Ms. McNulty?

Ms. McNULTY. The other side of that is what the American Hospital Association, I assume, is alluding to in putting a good faith exception in the statute. Is that correct?

Basically, that if the hospital relied in good faith on the doctor's representation, then the hospital wouldn't be responsible.

We have two objections to that. The first is that that goes against the current trend of the law, which does hold hospitals liable for the negligent acts of its emergency—I am sorry, for its physicians, and I discussed the doctrines and cases briefly in my written testimony.

I wouldn't go into that here, but I will briefly say that the reason for that trend is that increasingly patients look to hospitals, not individual doctors, for their care, particularly in emergency services. If you have a heart attack, if you have been hit by a car, you go a hospital emergency room to receive care from that hospital.

It is not fair to require a person in extreme medical distress to inquire of the emergency physician, "excuse me, before you treat me, are you an employee, are you an independent contractor, are you on call, are you a staff physician?"

That is ridiculous. The hospital ultimately should be liable.

Chairman STARK. Let me ask this—I guess I am inclined to agree, but let's suppose that somebody is liable for a civil penalty. The hospital itself cannot go to jail, so we have to find an individual under the Stark proposal, you have got to put the hospital administrator in jail or the doctor or both, but subsequent to the crime, can't the hospital and the doctor fight it out?

In other words, let us suppose the hospital—I mean, I would think somebody is in charge generally, and it is either—and I guess

it varies from hospital to hospital or emergency room to emergency room or department within various hospitals.

In some cases there is a doctor who is autocratically, dictatorially in charge of the way certain procedures move in a hospital, and in other cases, I suppose hospitals like HMOs go out and hire guys on salary, part-timers, and staff their emergency room. In some cases even a non-physician, maybe a hospital administrator, maybe running a department.

Can't you find out who is at fault after the fact or does this law make that more difficult?

Mr. MICHAEL ANTHONY. That is really how most malpractice cases are now handled. There is attribution of responsibility and sometimes it is shared. Other times it falls on the physician rather than the hospital.

What we are saying is this bill, H.R. 821, as proposed would put us in the position where the hospitals and the doctors would be absolutely liable. It would be a strict standard of liability.

What we are saying is that when a hospital can intercede, for example, if there is a pattern of negligence in the emergency room, they can then intercede because they have peer review and they are responsible for picking that up.

They should do so. If they elect to employ doctors in their emergency room and thereby assume a higher level of supervision and responsibility because they are employed, perhaps then they should be responsible because, again, it is a well reasoned body of law they should be controlling the actions of their employed physicians.

Otherwise, the hospital cannot control in an isolated incident in any way that discussion between a patient and the physician, and those decisions are made in an emergency room as to stabilization or whether there is an emergency condition without the benefit of a lot of consultation amongst hospital staff members.

Mr. GRADISON. Thank you, Mr. Chairman.

With regard to the nonemployed physician, it would seem to me the hospital should have certain responsibilities to review these cases and to examine whether to continue the privileges of the physician or to suspend them for a period of time, at very least if there is a pattern of such behavior.

Mr. MICHAEL ANTHONY. Oh, absolutely.

That is what we pointed out in our testimony and as well when I said that there should be vigilant peer review in place. That is a retrospective review, and they must take action when these kinds of activities are uncovered in that kind of vigilant review.

Mr. GRADISON. Mr. Anthony, you mentioned in your initial statement, and I didn't fully understand it, a possible conflict between State tort reform law and what we are talking about here today.

Could you help me understand better what you are referring to, please, or give me an example?

Mr. MICHAEL ANTHONY. There is created by the anti-dumping legislation a private cause of action which now in current law allows a patient who is affected by a dumping incident to bring a cause of action against the hospital and/or a physician if harm is rendered in the transfer process or as a result of the transfer. This is a Federal cause of action that would not be determined under State predicate, but rather under Federal law. Now all State tort

reform initiatives are applicable to State actions where malpractice claims, for example, are typically brought, and the current law requires that the decision at the Federal court level should be determined based on the State body of law.

What we are saying is that needs to be the case because the State body of law then is responsive to tort reform initiatives that are in place, and as you know, many States have debated the pros and cons of tort reform over the last ten years and most States have implemented some form of tort reform.

Ms. McNULTY. If I may add a perspective, we have seen four cases to date actually reported in our reporters, on private rights of action, and what we have found is that a dumping victim has the right to go into Federal court under the statute.

Normally, in a medical malpractice case, they would go into State court. They now go into Federal court, but their damages are limited by the State malpractice law, and in that sense they in no way violate or override a State's right to set its tort reform.

For example, in a State that says there will be no punitive damages in malpractice actions, a dumping victim cannot get punitive damages in Federal court. Otherwise, the statute does intentionally differ from common law in that it creates a duty to treat.

If you kick it back to the States, the statute will be completely eviscerated because in many States there appears to be no duty to treat patients, emergency or otherwise.

Mr. GRADISON. And common law would control in those cases?

Mr. MICHAEL ANTHONY. Common law would control, yes.

Ms. McNULTY. Yes.

Mr. GRADISON. May I ask one other thing which is somewhat tangentially related, Mr. Anthony? I have been concerned about the number of emergency rooms and trauma centers closing in many parts of this country. Frankly, I think I have been as much or more concerned about this than I have been about the hospital closings which you were talking about earlier this afternoon.

Is this happening with increased frequency as compared with past years, in Chicago, south Florida, Los Angeles, other places, and if so, what does it mean?

Mr. MICHAEL ANTHONY. I think more often than not what you are seeing is that the hospitals are more and more coming together with community groups and State regulators to try to define which types of facilities are in the best position to accept certain types of emergency patients, and there is an attempt to try to delineate the respective responsibilities of hospitals within a community, again on a community-specific basis, and that varies from community to community.

You have in some communities publicly funded institutions, in other communities you don't. The burden for the rest of the hospitals in the communities change, so there is a lot of discussion going on now as to proper apportionment of responsibility within a defined community by the hospitals, and some of that discussion has resulted in a lot of publicity about dropping out of trauma networks, but in many cases the hospitals have come back into the trauma networks after there were some discussions with the State about appropriate ambulance services, about appropriate responsibilities of the parties, and generally I don't see that major trend.

You have, again, varying responses in different communities.

Mr. GRADISON. Can you add to this, Ms. McNulty?

Ms. McNULTY. Briefly, the National Health Care Program has been very active in Los Angeles in attempting to halt the elimination of emergency rooms and 911 services in neighborhoods that primarily serve poor and black people. I guess I differ a little bit in my assessment of the situation, in that I see hospitals responding to their increasing patient loads for uninsured people and indigent patients by shutting down their emergency services altogether.

They are a real money loser, and this leaves uninsured and poor people completely at sea.

Mr. GRADISON. Sure is a clear-cut way to avoid getting sued for dumping.

Thank you, Mr. Chairman.

Mr. LEVIN [presiding]. Ms. McNulty, as I understand your suggestion, it would be possible for a hospital to be liable—absolutely liable—where a physician was not guilty of negligence but still there was a violation.

Doesn't it work out that way if you eliminate knowingly?

Ms. McNULTY. Well, for example, the situation I am describing is this. If there was a memo of transfer requirement, a piece of paper a doctor had to sign before she or he transferred a patient, if later it turned out that that transfer was a dump, an illegal dump, the hospital would then say, look, we had this piece of paper which we relied upon in good faith. You cannot, therefore, hold the hospital responsible. What I am saying is that, yes, the hospital should be responsible for its agents, the doctors.

Mr. LEVIN. That is what I am saying, though. If the physician made a mistake but would not be subject to a successful suit on the basis of negligence because he made a mistake. But if it wasn't a negligent mistake, the hospital under your approach is still absolutely liable.

See, I am not quite sure how you put those two together.

Ms. McNULTY. Well, in a government action there are, I think, three different things that can go on. The hospital can have its contract terminated, the hospital can be fined, and then the physician can also be held responsible.

I don't think—correct me if I am wrong—that standards are the same for those different actions. I do think that if a hospital failed to medically screen a patient or failed to treat an unstable patient, yes, it should be liable, and, yes, that is strict liability, and the reason we need that is because, one, this is a national public health problem. People are dying in hospital parking lots.

Two, if we don't require that, a hospital, I guarantee, will never be liable, and we will not be able to stop patient dumping.

Mr. LEVIN. You referred to the number of cases. Is that in your testimony?

Ms. McNULTY. You mean the HCFA investigations or—

Mr. LEVIN. You start off by saying that there were—I forget the figure, I didn't write it down, 500,000 or—

Ms. McNULTY. Oh, yes, that is in my written testimony.

Mr. LEVIN. What is that figure based on?

Ms. McNULTY. The estimated number of patient dumps was generated by a report of the Public Hospital Association, and I believe

was also confirmed by the inspector general's August 1988 report, and the data I have on investigations is the result of a conversation with HCFA Department of Survey and Certification last week.

Mr. LEVIN. I see it on page 3. The inspector general estimates a quarter of a million illegal patient dumps. Also, let me just ask you one other detail.

On page 9, you talk about causation. You would eliminate the word "directly", so if it were caused—or would you not require any proof of causation?

Ms. McNULTY. I am sorry, I don't have my papers in front of me. Basically, what we would want is that if a patient was, I guess—yes, we would want to eliminate the causation requirement.

The proof we would want to be required would be to show that a patient was subject to an illegal transfer or discharge, and a patient that was the subject of a transfer or discharge by a physician or hospital would have a right of action.

Mr. LEVIN. And there would be liability without the need to prove any causation?

Ms. McNULTY. Well, the causation is that they were the subject of the illegal action.

Mr. LEVIN. But let's say there was testimony that it had nothing to do with the result. There is direct causation and causation, and then no causation. You are suggesting we adopt a standard that there needs to be no proof of any causal relationship?

Ms. McNULTY. No. Let me give you an example, and then maybe that will help. It is in my written testimony, and we received many calls like this. An elderly woman was very sick, she was in diabetic shock, her family took her to a hospital. She was uninsured.

Upon learning that the woman was uninsured, the hospital refused to treat her and said—I think it was a Friday evening—"go to the free clinic on Monday after the weekend." The family accompanying her was very distressed upon this refusal to screen or treat her. They didn't believe the woman was well enough to be discharged.

The family took her to another hospital that same night, where she was admitted because she was seriously ill. Was this woman dumped?

Well, she didn't receive a medical screening at the first hospital, she was discharged in an unstable condition. The hospital violated the law, but this woman could not prove causation. She was very ill.

She was turned away, but she later received care at another hospital. The real problem the statute is getting at is the tremendous risk that the hospital practice of dumping causes.

That is what we are trying to deter—the creation of the risk. You will never be able to prove direct causation because people go to emergency rooms because they are already very sick and dying or in labor.

Mr. MICHAEL ANTHONY. Can I make one comment on that?

The civil money penalty powers, as well as the suspension powers of the Secretary and the inspector general are meant to be that deterrent. What we are talking about here is a well-reasoned body of law that has developed that establishes that there be some

harm to the patient proven before the patient can recover on a civil basis.

The hospital and the doctor in the circumstances that were outlined here would be subject to civil money penalty and/or exclusion from the program. What we are saying in terms of the hospital, if they could have controlled that medical decision, they should be held responsible.

If they can't, they should not. Again, there is a well-reasoned body of agency law that establishes when a hospital can be responsible and when they shouldn't be responsible.

Chairman STARK. If the gentleman would yield, then what you would suggest is if the patient dies, it is the death penalty for the doctor, is that what you are getting at? What is fair is fair.

Mr. MICHAEL ANTHONY. We have to look at what occurred with the civil money penalties.

Chairman STARK. If the civil money penalty isn't enough, how about the death penalty for the doctor?

Mr. MICHAEL ANTHONY. The suspension may still be appropriate.

Ms. McNULTY. If only seven hospitals have been fined when three-quarters of a million patient dumps have occurred since the enactment of COBRA, and the inspector general testified then that it cannot handle this case load right now, private rights of action are the key to deterring patient dumping. It is really important that the individual victims who know that a dump occurred and whose health is at risk be able to go into court and say to the hospital, and/or the doctor, you cannot do this.

Mr. MICHAEL ANTHONY. And we are saying if there is harm caused to the patient as the current antidumping law reads, then that action is available, but that action should be responsive to State tort reform initiatives.

Mr. LEVIN. Say there was no discernible harm, the hospital has still dumped, no?

Mr. MICHAEL ANTHONY. Dumping could mean, for example, you neglect to provide one piece of the medical record even though it may not be an instrumental piece. That is technically a violation of the act.

Mr. LEVIN. Then say it is not a perfunctory violation, the hospital dumped but somebody else picked up the problem, how do you get at that issue?

Because what it means in a lot of places if there is a facility that will take cases, another hospital can rely on that, so how do we then force or induce hospitals not to do this?

Mr. MICHAEL ANTHONY. If there is a dump—if the hospital that accepts the transfer is able to establish that there was a problem—then the inspector general and the Secretary again have very significant powers to impose very significant fines involving the hospital and the physician depending on who is responsible. They can exclude or suspend those providers from the Medicare program which has a very significant impact on the way they operate obviously and significant implications on how care is provided, but also there is a cause of action that can be brought by the patient under State law as well as under this new Federal cause of action. If there is harm that can be demonstrated was caused by the dump.

Chairman STARK. Mr. Anthony, if my colleague from Michigan will yield. First of all, the hospital who receives the patient and provides the service, what is the incentive for that hospital to go chase one of their colleagues up the street? They are not in the business of enforcing the law.

I mean, why should I rely on the good hospital, the good samaritan to go after the bad guy?

Mr. MICHAEL ANTHONY. First of all, your law requires that the dump be reported, and it is to be reported to the Secretary and the inspector general who go after the hospital and the doctor. The receiving hospital does not have to do so.

Chairman STARK. It sounds to me about as effective as if you see a car with less than three occupants in the high-occupancy vehicle lanes—

Mr. MICHAEL ANTHONY. \$50,000 fines are very—

Chairman STARK. The receiving hospital gets paid. They provided the service, they did the job, nobody died. The baby was delivered. Something happened. Now what is the incentive. I don't understand why that hospital is going to check up to see if the person was at another hospital. There is no incentive for the second hospital to go after the first hospital.

Certainly doctors never do it to each other.

Mr. MICHAEL ANTHONY. Right. But the patient can also put the inspector general on notice or the Secretary on notice. There are other ways for determining whether it happened.

Chairman STARK. The patient in this situation is usually poor, and therefore somewhat powerless to do these things. How does the hospital learn? It wasn't the hospital's fault. If it is the hospital's fault, I gather you would agree with me you don't care whether it is knowingly or should have known, if it is the hospital's fault. If it isn't, why can't they just go after the doctor?

Then you have got two rich people battling with each other, that is fair turf. If they are pushed in and the hospital says it wasn't my fault, it was Dr. Jones over here who made that decision, then let them fight it out. Why put this on the back of the patient?

Mr. MICHAEL ANTHONY. We are not trying to remove the rights of the patient to bring litigation or go after either the hospital or the doctor. We are just saying that there should be some decision made as to whether it was both the hospital and the doctor's problem, or whether it was created by the doctor without hospital involvement, and we are saying that we have to, around this Federal cause of action giving the patient the right to go after either or both put appropriate parameters. Or both. And they can go under the Federal cause of action and then go into State court and a medical malpractice charge, so there are many avenues available to the patient.

Chairman STARK. But why can't we go after the doctor and the hospital at the same time?

Mr. MICHAEL ANTHONY. As long as a decision is made as to who was responsible—

Chairman STARK. No. You would advise me, I will bet you, as a lawyer, if I were going to sue somebody for malpractice and you were in the PI business, you would have me suing everybody that we could sue and a few people we couldn't and someone we never

heard of and a bunch of John Does just for the hell of it to make sure. We might go bottom fishing and hit a big one.

Since that is what most lawyers would advise, actually, for fear of malpractice in the lawyer business for not advising me to hit enough people. Now why shouldn't I be able to do the same thing?

I mean, when you are going out and trying to punish somebody, why shouldn't you just name everybody, and then why should the poor patient, who can't really tell who is at fault anyway. Everybody runs around in white coats in hospitals.

How do they know who is the doctor and who is the hospital administrator?

Mr. MICHAEL ANTHONY. You are right, if there is any scintilla of a possibility that a hospital might be involved, they will be brought in if it is the medical judgment of the physician involved. Typically, the courts will decide whose fault it is. Again, we are not saying a patient shouldn't be able to bring an action against the hospital and the physician. But the hospital shouldn't be held strictly liable for any violation because the hospital may be solely in the violation of what constitutes active labor and emergent situation or stabilization of the patient.

The hospital should not be held responsible. H.R. 821 would put them in a position of absolute liability with no determination. We are not saying that the patient can't bring the action but the decision should be made as to who is liable.

Chairman STARK. Have you got it all figured out, counselor?

Mr. LEVIN. I think what we are trying to do is to fit all dimensions of a problem into the adversarial process in this country, and as a result we don't find out enough when there is a problem and when there is a failure on the part of the hospital, but also with absolute liability there could be an exception in a few cases, payment by hospitals when they were not to blame, so in a sense the system doesn't work on either ground. What we need to do, I think, is find whether the person was harmed or not, if there was an intentional omission by a hospital or physician, we need to be able to crack down on that, and where there was harm, give some compensation. I don't know how you write statutes to do that, but if we are going to simply rely on the adversarial procedure moving around definitions, we are only going to touch the top of the iceberg.

Mr. MICHAEL ANTHONY. We would be glad to work with you in trying to draft the appropriate legislation.

Mr. LEVIN. Even if there are a tenth of the 250,000 cases, if we are going to handle them strictly through the adversarial process, it wouldn't work. On the other hand, there will be some instances if we do that where hospitals will be hit with a verdict when they act in good faith.

Chairman STARK. But can't they in turn then go and collect from the doctor? Is there anything that precludes that?

Ms. McNULTY. Yes, they can.

Chairman STARK. If we make a mistake, can't the hospital then turn and collect from the doctor?

Mr. LEVIN. I suppose so, but I don't think that in the end gets at the basic function of this statute, and that is to unearth the apparently somewhat large-scale default on the part of hospitals when

they think that somebody else may handle it, and all this may be a function of under-effective hospital and medical system in this country.

If we are going to salvage strictly through the litigious procedures, we are likely to fail.

Ms. McNULTY. I think you are correct in noting that even the most effective antidumping statute is a bandaid approach to the ultimate problem, which is the lack of health insurance and inadequate insurance.

Chairman STARK. That is our next bill.

Mr. LEVIN. Now that we have resolved that—

Chairman STARK. Thank you. I appreciate the witnesses being so patient with me on this issue. I need a lot of enlightenment.

We will call on you for more information as we wind our way through this. Thank you very much.

Our next witnesses will discuss problems relating to inner-city hospitals. Jo Ivey Boufford represents the National Association of Public Hospitals; and Dr. David Kears, director of the Alameda County Health Care Services Agency, who will explain to us how we triage in Alameda County and hire ethicists to ration care to poor people. I assume he is not here recommending that anybody else will have to do that, but I am sure it will be interesting to learn more about that.

Dr. Boufford, would you like to proceed in any manner to enlighten us or expand on your testimony?

STATEMENT OF JO IVEY BOUFFORD, M.D., NATIONAL ASSOCIATION OF PUBLIC HOSPITALS AND PRESIDENT, NEW YORK CITY HEALTH AND HOSPITALS CORP.

Dr. BOUFFORD. I have a brief summary of my written testimony, which I will provide in writing.

Chairman STARK. The electronics in this room has not caught up with the 20th century. If you will swallow that microphone, it will maybe work.

Dr. BOUFFORD. I am happy to be here to represent the National Association of Public Hospitals which consists of over 85 public and nonprofit hospitals that serve as major referral centers, teaching hospitals, and hospitals of last resort for the poor and medically under-served in most of our nation's largest metropolitan areas.

This is a very important hearing on the crisis facing urban public hospitals and the inability of these safety net institutions to sustain any further reductions in Federal support.

First I want to thank you, Mr. Chairman, and members of this subcommittee, for your consistent support for public hospitals, especially your support for the disproportionate share adjustment which acknowledges the role these institutions play in caring for low-income patients, not just Medicare patients. We also appreciate your concerns about the adequacy of Medicaid and Medicare payments, your attention to the trauma care crisis, and your reintroduction of the Hospital Indigent Care Assistance Act.

First, let me briefly discuss the characteristics of urban public hospitals. We serve as the family doctor to growing numbers of people who lack access to health care services, the poor and the

medically indigent and those who, because of their ethnicity, age or social status or the complexity of their illness, have nowhere else to go. We represent a mere handful of metropolitan hospitals, no more than 200 or 300 in all out of some 6,000 nationally, but we provide and finance many of the services needed and used by those without access.

We are, in a sense, a national health insurance system by default. As safety net institutions, we differ from other community hospitals. We provide a huge volume of care, averaging 19,000 admissions per hospital compared to other acute care metropolitan hospitals which average only 7,000. We provide a disproportionate share of outpatient services, averaging 242,000 visits per hospital per year, compared to 50,000 visits provided by other metropolitan hospitals.

Our occupancy rates are considerably higher than other hospitals, 83 percent versus 67 percent. They have continued to increase while those for the rest of the industry have been declining. We have maintained a commitment as major teaching hospitals with a high average resident-to-bed ratio.

In addition, we provide many specialized services that are unprofitable and not offered by others, such as trauma care, burn units, neonatal intensive care, obstetrics, substance abuse detox, and inpatient psychiatric care. Public hospitals are at the forefront of the AIDS epidemic and treat a disproportionate share of AIDS patients. Nationwide, we treat 55 percent of the cases, though we have only 25 percent of the beds. We rely heavily on Federal, State and local funds to finance the care we provide and have very few privately insured patients.

Nationally, in these safety net institutions, 28 percent of the inpatient care was uncompensated and 42 percent of the outpatient care was uncompensated in 1987. Only 13 percent of our gross revenues was from private insurance. Since we care for all regardless of ability to pay, we are particularly vulnerable to Federal budget reductions. Increases in the medically needy population, decreases in Medicare coverage of costs, and declines in Medicaid coverage have affected our financial and programmatic situation.

To be specific, in New York City's public hospital system, the largest in the country, we face a number of pressing problems brought about by a combination of cost containment initiatives, regulatory pressures, and increasing patient morbidity. Our occupancy rates are soaring, often topping 100 percent. Our emergency rooms are overflowing with patients awaiting admission, frequently for days. We are experiencing an unprecedented increase in demand driven largely by AIDS and substance abuse and increases in mental illness, poverty, homelessness, the uninsured and the elderly. As a result, a greater proportion of our patients are in need of more intensive care, have longer lengths of stay and are more difficult to place in after care.

Every day we at HHC treat over 550 inpatients with AIDS, 22 percent more than we did last year. With 16 percent of the medical-surg beds, the public hospitals in New York treat 34 percent of the AIDS patients.

Drug abuse, especially crack, has led to an enormous increase in the utilization of our acute care resources. Over the past few years

at HHC, drug co-morbidities of our patients have increased 35 percent in medicine and 60 percent in psychiatry. In 1987, only 11 percent of our psychiatric ER visits were crack related. In 1988, 38 percent are crack related. We are experiencing a burgeoning demand for mental health services, fueled largely by deinstitutionalization policies of the State and inadequate development of community mental health resources.

We are also treating a growing number of uninsured and underinsured patients. More than 1.3 million people in New York City are without health insurance, and the Medicaid Program, a very generous one by national standards, only covers one-half of the poor under the age of 65. Uninsured patients who often delay care come in sicker because they delay.

We are also facing severe health personnel shortages, like many other institutions around the country, but shortages are more severe for public hospitals. In a very competitive market, the stress of working in relatively understaffed institutions and caring for difficult patients make it extremely difficult to attract nurses. Restrictions in the growth of Medicare have added to the financial strain of public hospitals. Though Medicare represents a small portion of total revenues for urban public hospitals, only 18 percent nationwide, it represents a substantial portion of the revenue from insurance.

Therefore, Medicare payment policies are extremely important to us, as we are increasingly burdened by the costs of uncompensated care. Local governments cannot step into the breach. A critical reduction in Federal payments is being contemplated, including reduction in the indirect medical education adjustment. Since public hospitals are major teaching hospitals, any reduction in this adjustment puts our financial viability more at risk. For example, a 1-percent reduction in the IME removes \$5.5 million from HHC hospitals alone, in the next fiscal year.

It must also be remembered that the indirect medical education adjustment serves as a proxy for the fact that teaching hospitals legitimately have higher costs because they treat more severely ill patients. I commend your careful and considerate attention to the needs of public hospitals as you move into reconciliation, and particularly, I urge you not to permit further reduction in the indirect medical education adjustment and to continue your support for the disproportionate share adjustment. I also urge your support for a full capital pass-through under medicare. We are competing with other municipal services for very scarce capital dollars.

Thank you.

Chairman STARK. Thanks.

[The statement of Dr. Jo Ivey Boufford follows:]

The situation is similar at public hospitals across the country, and greatly compromises the ability of these safety net institutions to continue to provide care to those who lack access. While our nation has considered solutions to the problem of uncompensated care that would permit all citizens access to every doctor and every hospital, we must acknowledge that a mere handful of metropolitan area hospitals provide and finance many of the services needed and used by the 37 million Americans who lack adequate insurance. We believe strongly that the federal government must take steps to protect and preserve this network -- a national health insurance system by default -- until an alternative solution is in place. Both HAPM and HHC recently supported the Health Benefits for All Americans Act as an important step in addressing the issue of uncompensated care.

Mr. Chairman, you and the members of this Subcommittee have been well aware of the importance of these safety net hospitals, as evidenced by your consistent support for the disproportionate share hospital adjustment; your concern about the adequacy of Medicaid as well as Medicare payment rates; your attention to the trauma care crisis; and your reintroduction this year of the Hospital Indigent Care Assistance Act. On behalf of all HAPM members and other hospitals serving the poor and medically indigent, I would like to commend these efforts -- and to urge your continued attention to their needs during your forthcoming budget deliberations.

In the remainder of my testimony this morning, I would like to provide you with some detailed current information in several of the areas outlined above, by way of support for your continued efforts to protect our nation's safety net hospitals.

First, I will describe in greater detail the current situation of major, metropolitan area safety net hospitals nationally, including some of the characteristics that distinguish these hospitals from the average American hospital. In this section, I will also describe the disproportionate impact on such urban hospitals of current health industry problems, such as the increased demand for uncompensated care, the growing crisis in trauma and emergency care, the nursing shortage, and AIDS.

Second, I will discuss current sources of financing for the essential services provided by these hospitals, through a fragile combination of federal, state, and local governmental funding.

Third, I will discuss our experiences in New York City, where we face special problems and demands for service.

Finally, I will conclude with several summary recommendations for the Subcommittee as you move forward with your deliberations this year.

I. The Situation of Urban Public Hospitals Nationally

Increased attention has been paid in recent years to the valuable hospital network that serves as the safety net for America's health care system. This network is comprised of a surprisingly small group of large teaching hospitals in our nation's metropolitan areas -- perhaps no more than two or three hundred in all, out of over 6,000 hospitals nationally. While there are a number of non-profit teaching and community hospitals within this network, the majority are government-supported facilities.

While these safety net hospitals operate under a variety of legal structures, they share a common mission and many common characteristics that set them apart from other community hospitals. These hospitals provide a significantly higher volume of inpatient and outpatient services than their private sector counterparts; they serve as the family doctor to an increasing number of people who lack access to private physicians; they have seen increases in occupancy rates while the hospital industry in general has seen occupancy rates fall; they provide many unprofitable medical services needed by their patients; and they are major educators of our nation's physicians and nurses. They are funded to a much greater degree than other hospitals by governmental sources (local, state and federal), and typically have a much lower proportion of privately insured patients. They continue to bear an

enormous and increasing share of the burden for care to the poor in comparison to other segments of the hospital industry.

The information I will present describes some of the distinguishing characteristics of these safety net hospitals, drawing on data from our as yet incomplete 1988 NAPH survey. While this data relates only to NAPH member hospitals, we believe our sample is sufficiently large (approximately 50 hospitals responding to our surveys, with gross revenues in excess of \$6 billion) to enable you to draw some conclusions about this segment of the industry as a whole.

A. Volume of Services

Although NAPH member hospitals are few in number, they provide a huge volume of care, and that volume continues to increase. In 1986, for example, NAPH hospitals averaged 19,050 admissions per hospital, while other short-term acute care hospitals in the same metropolitan areas averaged only 7,038 admissions per hospital. NAPH members also provided a disproportionate share of outpatient services, averaging over 242,000 visits per hospital in 1986, compared with other short-term community hospitals, which averaged only 50,414 visits per hospital.

B. Occupancy Rates

Another striking difference between NAPH member hospitals and other community hospitals is illustrated by hospital occupancy rates, and by the continued increase in these rates at a time when occupancy rates in the rest of the industry have gone down. The AHA reports that occupancy rates for community hospitals have been declining, from 69% in 1984 to 67% occupancy in 1986. For NAPH hospitals, however, the rates have been considerably higher and remain so. In 1984, occupancy rates for NAPH members averaged 79%, and climbed to 83% in 1986.

C. Teaching Commitment

NAPH members have maintained their commitment as major teaching hospitals, as well, with member hospitals averaging 173 residents per hospital in 1986, with an average ratio of .35 residents per bed. (The Council of Teaching Hospitals considers a ratio of over .25 to be a major teaching commitment.) At HHC, we have a long-standing commitment to training future physicians and dentists through an Affiliation Program with major medical schools and voluntary teaching hospitals which provide professional services in HHC hospitals, including supervision of graduate medical and dental education programs. HHC has about 3,000 residents/fellows in its hospitals, representing about 36 percent of all training slots in New York State.

D. Trauma Care and Other Specialized Services

In addition to providing care to the poor, NAPH hospitals also provide many specialized services needed by their patients that are unprofitable and, consequently, are not offered by many other hospitals in the community. For example, NAPH hospitals are three times more likely to be designated a trauma center than private facilities. Seventy-six percent (76%) of NAPH member hospitals are designated as trauma centers, while only 24% of other short-term acute care hospitals provide this service. As you are aware, hospitals in some parts of the country are now dropping their trauma center designations and are even seeking ways to curtail their emergency room services.

Thirty-nine percent (39%) of NAPH hospitals have a designated burn center, while only 3% of other community hospitals have such designations. One hundred percent (100%) of NAPH hospitals provide organized outpatient services, while the community hospital average is 65%. Seventy-four percent (74%) of NAPH members provide neonatal ICU services, as compared with only 14% of other community hospitals. Forty-one percent (41%) perform open-heart surgery, compared to 17% of other hospitals. NAPH hospitals are also more likely to offer psychiatric services: 78% offer inpatient psychiatric services, as compared with 39% of other hospitals.

The costs associated with the provision of these specialized services can be burdensome. For example, many inner-city trauma centers provide a high proportion of uncompensated care associated with gunshot-wound victims and other victims of violent crime. The cost of such treatment is high and, most often, patients have no insurance or other means to pay for it.

E. AIDS

NAPH member hospitals have also been at the forefront of the AIDS epidemic, treating a disproportionate share of the AIDS population, and that burden is also increasing on both the inpatient and outpatient sides. According to an NAPH study of the financing and care of AIDS patients in U.S. hospitals, NAPH member hospitals treated 55% of the AIDS patients included in the survey, but represented fewer than 25% of the beds.

We have some dramatic statistics on the sources of payment for AIDS care in public hospitals. Only 8% of AIDS patients in 1985 were covered by private insurance. Twenty-five percent (25%) were described as "self-pay" or "other" patients, a good proxy for non-paying patients; these patients are dependent on state and local subsidies for their medical care. Sixty-two percent (62%) were covered by Medicaid (pointing to the importance of that Program in the financing of AIDS care). Roughly 3% are covered under government programs for care of prisoners. Medicare covers only a small fraction of AIDS patients -- about 1%. In all, 92% of the AIDS patients treated in public hospitals were supported by some kind of government program or funding.

Preliminary data from 1987 indicate that the payor mix for AIDS patients is shifting from federal to state and local government payors: the percent of Medicaid payments has decreased to 54%, while the self-pay/other sources of financing have increased to 33%. Private insurance represented 9% of admissions and Medicare was up very slightly to 2%.

F. Care to the Uninsured and Underinsured

Although all of the characteristics outlined above distinguish safety net hospitals from other health care providers, it is their open doors for the medically disenfranchised that make these hospitals particularly vulnerable to federal budget reductions. The financial and programmatic situations of these hospitals have been affected by several factors, including increases in the medically needy population, decreases in Medicare coverage of costs, and declines in Medicaid coverage.

In 1985, NAPH hospitals averaged 167,184 inpatient days per hospital, of which 42,877, or 25.6%, were considered bad debt/charity care. By 1987, bad debt/charity care represented over 28% of patient days (an average of 51,768 uncompensated days out of 180,052 total days per hospital). On the outpatient side, NAPH hospitals averaged 278,463 visits per hospital in 1987, of which 116,136, or 42%, were bad debt/charity care visits.

For some individual hospitals, the percentages of bad debt and charity care were much higher. For the Harris County Hospital District, in Houston, Texas, for example, bad debt/charity care represented 79% of all inpatient days and 79% of all outpatient visits in 1987. Parkland Memorial Hospital in Dallas reports that bad debt/charity care accounted for 47% of inpatient days and 44% of outpatient visits in 1987.

G. Health Personnel Shortages

NAPH hospitals are among the biggest losers in the current nursing and manpower shortages being experienced in today's health care marketplace. A recent NAPH survey shows that 49 safety net hospitals had an average 16% vacancy rate for registered nurses. Hospitals nationwide had a 11.3% vacancy rate, according to the ANA. These statistics, in combination with the above-mentioned increases in occupancy rates for public hospitals, point out a severe problem that needs to be addressed at the federal level.

According to the NAPH survey, the RN shortage in public hospitals is made worse by a lack of funding, making it difficult to compete with private

sector wage increases and bonuses. In addition, 41% of responding hospitals indicate that the types of patients they serve and the level of services they provide also hinder recruiting efforts. (These factors apply to recruitment of physicians and other health professionals, as well as nurses.)

The nationwide nursing shortage has forced safety net hospitals to allocate relatively more of their scarce resources to nursing salaries. Boston City Hospital, for example, gave a 24% raise to nurses last year and had to spend increased sums on overtime and agency fees. At the New York City Health and Hospitals Corporation, over the last two years the number of shifts per week provided by per diem nurses increased 168%, from 29,000 to 79,000.

II. Financing of Care

A. Sources of Revenue

Payments for the care of low-income patients, through Medicare, Medicaid and city, county, and state funds, continue to represent the major source of revenue for large urban public hospitals. In 1987, private insurance represented only 13% of gross revenues and 19% of the net revenues for NAPH hospitals. Funds for the treatment of low-income patients represented 61% of net revenues, at an average of \$71.01 million per hospital (\$39.65 million for Medicaid and \$31.36 million for local/state funds).

As I mentioned earlier, although Medicare payments represent a relatively smaller portion of the total revenues in major urban public hospitals than in the private sector (at 18% nationally, 10% in New York City), Medicare nevertheless represents a substantial proportion of the "insured" patient population and, therefore, Medicare payment policies are extremely important to safety net hospitals.

In recent years, as in the rest of the hospital industry, Medicare payments have failed to keep pace with inflation -- due in large measure to FFS update factors below the hospital market basket, reductions in the indirect medical education adjustment, and reductions in payments for capital costs. While the disproportionate share hospital adjustment has been invaluable to NAPH members, the removal of the 15% adjustment cap has not made up for the decreases in other aspects of the Medicare program.

One of the options being considered by Congress to achieve savings in the Medicare Program is a further reduction of the current add-on payments to teaching hospitals to finance the indirect costs of graduate medical education (IME adjustment). Since its inception, the IME adjustment has been intended to serve as a proxy to account for a number of factors which legitimately increase costs in teaching hospitals, and which are not otherwise accounted for in the DRG case classification system. These factors include the extra demands placed on the hospital staff as a result of the teaching activity. In addition, Congress recognized that the payments were also meant to account for factors not necessarily related to medical education which may increase costs in teaching hospitals, such as more severely ill patients who require special services and treatment programs, increased use of diagnostic testing, and higher staff-to-patient ratios.

As the Committee is well aware, Congress has slowly chopped away at the adjustment over the past four years. The current adjustment is 7.65 percent for each increment of 0.1 in the ratio of interns and residents to beds. Despite the reduction in payments however, NAPH hospitals have continued their commitment as major teaching hospitals.

Philip Lee, M.D., Chairman of the Physician Payment Review Commission (PPRC), testified at a recent hearing before this Subcommittee that Congress should not cripple those hospitals that rely on the IME adjustment. NAPH member hospitals are the very hospitals Dr. Lee was talking about. HHC is only one case-in-point: each 1% reduction in IME would remove about \$5.5 million dollars from our hospitals in the next fiscal year.

It should be noted to the Subcommittee that the factors that contribute to higher costs in teaching hospitals -- the factors for which IME adjustment

was intended to compensate -- have not gone away. If anything, these costs have increased. The non-Medicaid uninsured caseload of public hospitals has substantially increased in recent years.

When Medicare payments are reduced, the local governments that own public hospitals must make up the shortfall. This is becoming an ever increasing strain; many local governments simply are unable or unwilling to make up for losses in Medicare payments.

B. Operating Margins

A very important indicator of a hospital's financial condition is its overall operating margin, or revenues over expenses. The typical NAPH hospital has had and continues to have a negative margin, a result of revenues inadequate to cover costs of care. In 1985, NAPH hospitals' average net revenues were \$111.6 million. Average expenses were \$118.46 million. Therefore, on average, NAPH hospitals had a deficit of \$7.06 million, for a margin of -6%.

Forty-eight percent (48%) of NAPH member hospitals reported a deficit in 1985. For those hospitals with a deficit, the deficit averaged \$24.48 million. By 1987, there had been a small improvement in the deficit situation among NAPH members. However, the average margin was still negative. NAPH members reported average revenues of \$117.76 million per hospital and average expenses of \$123.96 million. The average margin was -\$6.26 million or -5%. In spite of this small improvement, however, 48% of NAPH hospitals still remained in a deficit position, and the average deficit of these hospitals was over \$14 million.

III. The Situation in New York

A. Demand

In recent years there has been an unprecedented increase in demand for hospital services. Increases have been driven by the twin epidemics of AIDS and substance abuse, increases in mental illness, poverty, homelessness, the uninsured and the elderly. As a result, a greater proportion of hospital inpatients are in need of more intensive care, experience longer stays, and are more difficult to place in after-care facilities. Public hospitals are affected disproportionately, since they traditionally care for the poor and uninsured. Almost forty percent of the patients in HHC facilities had three or more secondary diagnoses, and over 16 percent had five or more in 1988. The impact of more complex cases can be seen in the average length of stay, which was 9.3 days in 1988, compared to the national average of 7.2. The difficulty of timely discharge because of the shortage of after-care resources increased the average length of stay to 10.2 days.

1. Demand: AIDS

Over one-fourth of the nation's AIDS cases, an estimated 7,000 live cases today, are in New York City. The City's need for hospital beds for AIDS patients doubled between 1985 and 1987, and by 1988, the average daily hospital AIDS census was 1,700. By 1994, AIDS cases may approach 12,000 cases, with an estimated average daily hospital census of 3,800.

The impact of AIDS on public hospitals is particularly severe. With only 16 percent of the City's total medical beds, HHC provides 34 percent of the beds needed for AIDS patients. HHC's inpatient census has increased 22 percent over the past year. Every day there are over 550 AIDS inpatients in its facilities. Until recently, HHC's 84 long-term care beds dedicated to AIDS patients were the only ones available in New York City.

The complexity of the disease necessitates an enormous allocation of resources. Average lifetime cost of AIDS treatment for an individual patient nationally is about \$60,000. This year, New York City will spend approximately \$120 million in tax levy funds for the care of AIDS patients at HHC alone.

2. Demand: Substance Abuse

Drug abuse is 50 percent more common than it was ten years ago. The increased use of crack, in particular, has increased utilization of medical resources. From 1985 to 1987, medical complications of drug use requiring hospitalization grew 35 percent and psychiatric complications grew 60 percent. In addition, the majority of New York City's AIDS cases are related to IV substance abuse.

HHC's facilities treated 54 percent of those requiring hospitalization because of drug abuse, and 69 percent of those requiring drug-related psychiatric treatment. Half the patients in HHC's psychiatric facilities have drug comorbidities. In 1988, thirty-eight percent of HHC's psychiatric emergency room visits were crack-related, up from only eleven percent in 1987.

3. Demand: Mental Illness

A burgeoning demand for mental health services has been fueled by a variety of developments, most importantly the steady deinstitutionalization of State psychiatric patients without concomitant development of local community-based services. Other factors affecting demand are the growth of drug abuse, poverty, and homelessness.

Psychiatric units throughout the City have traditionally operated at full capacity. However, hospitals are seeing more multiproblem patients who are more difficult to diagnose, treat, and discharge appropriately. The hospitalized population is increasingly dominated by patients who are chronic schizophrenics, dually-diagnosed -- especially drug related and mentally retarded -- and homeless.

HHC serves fifty percent of all psychiatric patients. In spite of a 70 percent increase in the City's psychiatric beds, occupancy rates consistently hover at or above 100 percent, with 50 to 60 patients per day awaiting admission in psychiatric emergency rooms. The average wait for admission ranges from 2 hours to 28 hours.

4. Demand: Medically Indigent

With increases in poverty and an ongoing shift in New York's economy from manufacturing industries to service industries, which traditionally provide fewer benefits, have come increases in the medically uninsured; over one-fifth of the City's population under 65 are without coverage -- over 1.3 million people. In addition, Medicaid has not expanded sufficiently to cover the growth in the number of people who are poor; only half of New York's poor under the age of 65 are presently covered by Medicaid.

The key to receiving necessary medical care is health insurance; without it, low income New Yorkers do not have access to a personal physician, most likely will not be able to take advantage of primary and preventive medical care. Uninsured patients who delay care are often much sicker than the typical patient, require more intensive care, and increase the burden of uncompensated care for hospitals.

Total statewide charity care in New York State in 1987 was approximately \$1 billion, of which \$425 million was provided by New York City public hospitals. This high level continued to increase through 1988, and is expected to continue through 1989.

The increasing numbers of the homeless poor, who often reach hospitals in a very deteriorated physical condition due to malnutrition and exposure, have had a significant impact on hospitals. Since they lack a support system once their immediate medical conditions are stabilized, they cannot be easily discharged and often have unnecessarily long hospital stays.

B. Hospital Utilization

Since 1986, occupancy rates in New York City's med/surg units have climbed steadily, from a low of 82 percent to 100 percent or above. Indeed,

occupancy rates have hovered around 100 percent for over a year. This is in excess of the State-recommended level of 90 percent. The situation is particularly severe in medicine services at HHC, where occupancy was 112 percent throughout 1988. Similar overcrowding exists in psychiatry, obstetrics and neonatal beds. As of January 1989, on any night, some 600 patients can be found awaiting admission in emergency rooms. Many factors suggest that the City's hospitals are neither designed, staffed, nor organized to operate at occupancies of 90 to 95 percent and above, and when forced to do so, internal dysfunction begins to slow operations and compound problems.

C. Supply/Systems Imbalance

New York City's bed capacity was reduced to the point that no margin was available to cope with unforeseen increases in utilization through State reimbursement, regulatory and planning policies, which have been focused narrowly on cost control and inpatient bed reduction. Since 1982, 15 percent of the City's med/surg beds (4096 beds) have been closed. Even as utilization pressures began to mount, stringent reimbursement penalties forced hospitals to decertify 1016 beds in January of 1987.

Over one-third of the City's bed closures were absorbed by HHC. At the end of 1987, when state officials began to call for addition of beds, these closings proved largely irreversible due to conversion, renovation, decompression or other operations and staff shortages.

The state and Federal policies aimed at downsizing the most expensive part of the system -- inpatient care -- and encouraging the prompt movement of patients out of acute care facilities followed a national trend of reorganization of health care delivery around less costly primary and ambulatory care to prevent hospitalization, and long term care to facilitate early discharge from hospitals. However, State actions were not accompanied by regulatory policies and reimbursement incentives to expand alternatives to hospitalization. Medicaid reimbursement to private physicians, for example, is lower than Tennessee's, and fewer than 15 percent of physicians state-wide accept Medicaid patients, leaving emergency rooms as the only option for many recipients. Rates for hospital outpatient department services have been capped at \$60 for the past decade. Until recently, there was a moratorium on long term care beds and even now, unrealistic capital cost restrictions exist which will discourage construction of new long-term care beds.

The State's policy of deinstitutionalization has reduced the number of State psychiatric center beds from 93,000 in the mid-1950s HHC's to approximately 18,000 today, including the closing of 2,000 beds in the past year. However, the lack of community-based services left a large part of this vulnerable population with nowhere to turn for mental health services except New York City's hospitals.

Despite the obvious impact of drug abuse on acute care resources, including its relationship to AIDS, psychiatric incidents, and medically compromised infants, the State has developed no strategy for expansion of drug treatment resources. Treatment programs in the City can accommodate only 10-15 percent of those requiring services; waiting periods for drug detoxification beds range from weeks to months. Long term residential rehabilitation beds operate at 110 percent occupancy, with as many as 1,000 patients on waiting lists of up to six months. Ambulatory detoxification programs are almost non-existent.

D. Health Manpower

The largest single barrier to addressing the unexpected increase in demand for the immediate future is the shortage of health care personnel, primarily nurses. While this is a national problem, the shortage is more severe in New York City, and most severe in the City's public hospitals. With keen competition for a dwindling pool of nurses, the added stress of working in understaffed, over-crowded facilities, and caring for a patient population requiring more specialized forms of care, makes recruitment even more difficult.

HMC facilities are lacking more than a thousand staff Registered Nurses. A recent Health Systems Agency (HSA) survey found 879 acute care beds in the city unavailable for patient care solely because they cannot be staffed, 178 of these at HMC. Plans for adding desperately needed beds to the systems are being threatened because of these shortages.

The nursing shortage has forced hospitals to close entire units, restrict admissions to certain services, deny elective admissions, divert patients to other facilities, and delay transfers from the emergency rooms to nursing units.

In 1987, New York City hospitals had some 20 percent fewer full time equivalent personnel than did hospitals in the four next largest cities in the Nation. While nursing shortages are the most apparent, similar shortages exist for laboratory and radiology technicians, occupational, physical and respiratory therapists, pharmacists and social workers. Not only do staff shortages cause beds to be removed from service, they also cause operational inefficiencies and dysfunctions in producing vital services needed to treat and discharge patients in a timely manner.

E. Health Care Financing

New York State hospitals have been under a very tightly controlled reimbursement system since the 1970s. With the adoption of per case payment in 1988, all hospital revenues are now controlled entirely either by the federal or state government, with virtually no latitude for hospitals to increase inpatient revenues. While hospitals in the 49 other states have averaged positive financial margins for the past several years, New York's hospitals have experienced overall losses.

New York's rates are based on 1981 costs and subsequent adjustments have been inadequate to reflect technological advances or to fully recognize personnel salary increases or the cost of caring for sicker patients.

Although the creation of the Bad Debt and Charity Care Pool has provided some relief for uncompensated care and prevented the wholesale "dumping" of uninsured patients on public hospitals, it cannot support the current service load nor address the increasing bad debt burden. The fact that third parties are not paying the full cost of hospital care increases public hospitals' reliance on city revenues. As the financial viability of non-public hospitals is threatened and services are reduced or eliminated, the pressures on overstressed municipal hospitals will become even greater.

IV. CONCLUSION

In conclusion, I must emphasize that the pressures which are straining metropolitan health care systems throughout this country are not likely to abate, and will have a disproportionate impact on the public hospitals who care for sicker patients with more complex medical and social needs. Increasing poverty, AIDS, substance abuse, and mental illness will continue to present special challenges for public systems of care. The manpower shortage and tighter reimbursement controls will further strain our already overburdened acute care hospitals that are mandated to treat all regardless of ability to pay.

We at HMC continue to be absolutely committed to providing the highest standard of medical care to all New York's citizens. The challenges we face will prod us to maximize the use of our limited resources and make the most effective use of the various components of our system. These challenges have only strengthened our resolve to improve our services.

At the same time, we will continue to press for public policy which assures access of poor and uninsured populations to essential health care. Municipalities cannot continue to bear the increasing burden of costs for the uninsured, and state and Federal action to improve and expand public programs is urgently needed. Clearly, this is no time for a reduction in state and Federal support for our health care system. Both the indirect medical education adjustment for public teaching hospitals and the disproportionate

share adjustment are critical components to the survival of our most vulnerable safety net hospitals. I commend your careful and considerate attention to the needs of our hospitals and urge your continued support as you develop a legislative agenda for the new Congress. Thank you for this opportunity to discuss the vital issues confronting this nation's public hospitals.

Chairman STARK. David.

STATEMENT OF DAVID J. KEARS, DIRECTOR, ALAMEDA COUNTY
HEALTH CARE SERVICES AGENCY

Mr. KEARS. Thank you.

Again, Mr. Chairman, members of the committee, I am David Kears, I am director of the Alameda County Health Care Services Agency. In that capacity I oversee six departments, two of which are public hospitals, and an overall budget of approximately \$300 million.

I am pleased to have this opportunity to testify on the particular problems of urban hospitals, particularly urban public hospitals. The urban health care system in Alameda County and in the State of California is approaching its meltdown stage. Patients denied primary care clog our emergency rooms and the very sick patients waiting for acute care beds crowd out the less sick. Trauma systems throughout the State are breaking down, and movement from acute to long-term care is almost nonexistent for the Medi-Cal patient needing complicated care except on the county subsidies added to it.

The capacity is stretched to its limit. What care is not rationed is compromised by patient overload and demand. This crisis did not happen overnight, and no one factor precipitated it. It is a crisis borne out of years of neglect, compounded by the recent urban epidemics of crack cocaine, AIDS, homeless and the growing cost of trauma care for gunshot victims of drug wars. We did an estimate where it was somewhere \$20,000 to \$25,000 per incident every time somebody was brought in with a gunshot wound. That didn't include the incidents where you had long-term rehabilitative care. The number of working residents in Alameda County in the State of California without insurance or adequate insurance has been growing steadily. In the face of these mounting pressures, metropolitan area public hospitals continue to serve as a national health insurance, again by default, for the uninsured and the underinsured.

In my prepared testimony, I described with considerable detail the situation of urban safety net hospitals nationally, in California and in Alameda and in Los Angeles Counties. In the balance of my oral statement this afternoon I would like to focus your attention in particular on Alameda County.

The hub of the Alameda County health care system is Highland General Hospital, a general acute facility located in central Oakland. In addition to general medical and surgical services, the hospital offers a broad range of specialty services, including perinatal care, obstetrics, neonatal services and was also recently designated as a trauma center for northern Alameda County. Most of Highland's patients live in the low-income areas of Oakland.

Reflecting the general health pattern of low-income urban communities, the hospital patients are sicker, and they have more complex medical problems than the general population. Only 2 percent of Highland's patients are referred by private physicians. Almost 80 percent of all admissions come through the emergency room, and we are at 90-percent occupancy almost at all times.

Demand for services at Highland is rising dramatically. During the last 8 years total admissions have increased by almost 50 percent, and the number of outpatient visits rose just from 1 month this year from 1 month last year, using March as an example, by 25 percent. Because resources have not expanded to keep pace with the demand, the average waiting time for clinic visits at Highland is rising rapidly. For example, between April, 1987 and April, 1989, the average waiting time for a new appointment to our chest clinic rose from 5 weeks to nearly 13 weeks, and in the renal clinic it rose from 5 weeks to 10 weeks. A new appointment in the ear, nose and throat clinic now entails a 6-week wait. Bed availability can be delayed 20 hours or more, and waiting time for an emergency appointment can exceed 6 hours.

One of the things that was referenced in some of the earlier testimony is the importance of getting to a hospital. Quite frankly, in reality, it is almost irrelevant now how quickly you get to a hospital. It is how quickly you get seen once you are there. It is not because we don't have physicians on staff. It is simply because they have no ability, the system is so overloaded, that the time it takes to get to people can be, again, 6, 7, 8, 10, as many as 12 hours, just getting, once you are in the emergency room, to be seen.

We did an analysis for our Board of Supervisors recently. When they asked us what would it take, just seeing the patients who come into your door now, not broadening our service to anyone, but just trying to look at what it would take in order to see everyone brought in the emergency room within 2 hours, to provide everyone who is determined to need a bed within 4 hours, and to provide within 1 week an appointment for an outpatient clinic for those determined to need it. It would take about \$78 million augmentation to our \$100 million budget just to accomplish that. Only \$25 million of that would be offset by any Medi-Cal or Medicare revenue.

The urban issue of AIDS, drug abuse, homelessness, violent crime, plague our agency. Alameda County delivers only 4 to 5 percent of all babies born annually in California, but we deliver up to 25 percent of the babies that are born with congenital syphilis. Over 40 drug addicted babies are born to Highland each month, and we are not the primary high-risk delivery facility in the county. We have the fourth largest AIDS population in our State.

In the face of these growing urban problems and limited resources, we operate on a triage principle: giving treatment to one delays treatment to another. I have been making our clinics available. Each treatment decision has consequences for other patients. What we have done, and I will speak off these notes here, when we talked about the issue of rationing, it has got a lot of attention, and in some ways it is a misnomer, because it implies we are proposing to do something that doesn't already happen. The fact is we ration care now in the major urban cities. We ration it by default, we ration it by making access difficult to get, by creating obstacles in the ways of those who come for care.

What we have said, in effect, is we are not going to get any money primarily from the State, because, again, our Medicare revenue is similar to what New York talked about, it is only 10 or 12 percent, so the major problem we face is the 50 percent for which there is no pay and the inadequate reimbursements on the Medic-

aid side, but all that being what it is, the fact is that there is no more money, however way you want to play it. It is a zero sum game, and we are not going to get more money. The only way we can survive is to take a look at the money we do get and to see if these issues are faced up front and dealt with in a more open way, we can find a better way to spend that money, or at least put some pressure on those who make larger policy issues to accept the system for what it is and to take some responsibility for the hard choices.

I might add, we hired an ethicist not to make the decisions but to try to help us look at some of the broader issues that are involved. Quite frankly, most of our clinics are too busy to even think about that, let alone try to integrate into some kind of overall policy, and in a sense what we are dealing with is—we do it now—is the old issue of we both thin the soup and we lengthen the line. There isn't enough out there to feed or to serve everyone who needs it, and if we fool ourselves to think that it isn't being done or is being done in a proper way, I mean we are just deceiving the poor more so than our services do now.

You have mentioned in here, and it has been referenced, some proposed changes in Medicare payment policies. I echoed that which was shared by New York, education is important. I don't have to tell you that we have a two-tier, if not three-tier system today. The second tier is the system of care that is compromised simply by the amenities and the facilities and the length of time that it takes for people to get care. The third tier, quite frankly, is the growing number of people who get no care whatsoever, let alone compromised access to care.

But the one thing we have not compromised, at least in our county and throughout most of California, is the quality of the staff, and believe me if you start pulling back on the subsidies to the teaching programs and force us to compromise that, changing our teaching programs in any way, that is the next issue that gets compromised. We need the best staff available. As I said, we can't promise everything, but if we can give them the best staff, at least we can manage a little bit better with other limited resources we face.

In terms of the importance of disproportionate share, again the money is insignificant in the sense that it is not going to stabilize us, it is not going to solve the problems that I or Dr. Boufford alluded to, but it is a signal. It is a signal from the Federal Government that it realizes not all hospitals are alike, that some have a disproportionate share of the burden of caring for the poor, and that has to be recognized and it has to be supported, and that any kind of change in the system takes cognizance of that reality.

The last issue I want to reference is that one of the whole issue of capitalization. Almost all of the public facilities are dilapidated facilities. Many of them operate out of things not designed for what they are currently being used for. There is absolutely no way in the world that there is going to be any projection for increased revenue sufficient to do any kind of real debt financing.

So if we expect to have any facilities that meet any kind of fire codes or any other kinds of codes, we are going to have to have direct help from the Federal and State Governments. I doubt very

much that any one player in this game, be it the Federal, State or the local counties, is going to make this happen alone. But at the same time, none of them is going to make it happen unless they see participation at the Federal, State and local levels, and we ask for your support in that.

Thank you very much.

[The statement of David J. Kears follows:]

ALAMEDA COUNTY
HEALTH CARE SERVICES
AGENCY



DAVID J. KEARS, Agency Director

AGENCY HEADQUARTERS
488 FORTH STREET
OAKLAND, CALIFORNIA 94607
(415)

STATEMENT OF DAVID J. KEARS
DIRECTOR
ALAMEDA COUNTY HEALTH CARE SERVICES AGENCY

before the
HOUSE WAYS & MEANS COMMITTEE
SUBCOMMITTEE ON HEALTH

May 15, 1989

Mr. Chairman, Members of the Committee, I am David Kears, Director of the Alameda County Health Care Services Agency. In that capacity, I oversee six health departments, including two public hospitals, with an annual overall budget of \$300 million. I am pleased to have this opportunity to testify on the impact of Medicare and Medicaid funding decisions, increased demand for emergency care by the uninsured, and other recent health system changes, on the situation of our nation's important "safety net" hospitals.

The urban health care system in Alameda County and in many others parts of California is approaching "melt down". Patients denied primary care clog our emergency rooms, and very sick patients waiting for acute care beds crowd out the less sick. Trauma systems are breaking down in Alameda, Los Angeles and other counties, as private hospitals close their trauma centers and/or emergency rooms. Movement from acute to long term care is almost non-existent for the low income patient needing complicated care, and then only when Medi-Cal or Institute for Mental Disease subsidies are provided. Everywhere capacity is stretched to its limit, and what care is not rationed is compromised by patient overload and demand.

This crisis did not happen overnight, and there is no one epidemic, factor or circumstance that precipitated it. It is crisis born out of years of neglect and compounded policy failures. In Chicago, New York, Los Angeles, Kansas City, New Orleans, and many other cities, the story is the same. Factors contributing to the crisis include the recent urban epidemics of crack cocaine, AIDS, and the growing costs of trauma care for gunshot victims of drug wars.

And in California:

- Medi-Cal reimbursement rates or negotiated contract amendments have been frozen or allowed to rise at a rate insufficient to attract and retain providers, or at a rate not reflective of actual operating costs.
- Direct State and Federal payments have diminished or have not kept pace with inflation.
- State dollars that have been forthcoming are too often categorically linked (tied to new mandates, programs, or targeted problems) and thus not available to address broad system deficits.
- While there have been many new State mandates, relatively few have funding associated with them.
- The number of working residents in Alameda County and California without insurance or with inadequate insurance has been growing steadily (and now stands at approximately

20% of population), negatively impacting the revenue base at both public and private facilities.

- Much of the efficiency and improved productivity that is possible within public facilities is dependent upon costly renovations or construction and new medical technologies, for which no direct State appropriations have been available for years. Support that is available requires debt financing which no longer can be offset by projected increases in revenue/reimbursements.

Integral to each of these points is the preoccupation by State and Federal policy makers with budget considerations at the expense of service impact. State and Federal officials either block out or deny the reality that standards of care, access, or scope of services are predominantly determined by the level of funding available. By focusing on only one side of the equation -- budget concerns -- they have distanced themselves from the clinical and ethical consequences of their actions. Something has to give; and in this State, what has been increasingly sacrificed is access to care for the poor and disadvantaged.

Mr. Chairman, we again applaud the leadership you and the members of this subcommittee have shown in recognizing the vital role of metropolitan area safety net hospitals. Through your actions to improve the adequacy of Medicaid coverage for the nation's poor and near-poor, your support for the disproportionate share adjustments, your attention to the growing crisis in trauma care, among other actions, you have continually demonstrated crucial support for these urban public hospitals. In the forthcoming budget debate, we urge you to pay careful attention to the impact of your decisions on our most vulnerable safety net hospitals.

In other testimony delivered this morning, the current situation of major, metropolitan area safety net hospitals nationally, current sources of financing for these hospitals, and the disproportionate impact on such hospitals of current health industry problems is described in detail. I will summarize some of these matters, and will illustrate them with a look at some of the pressures on hospitals in Alameda County and other urban areas in California. I will also address the impact of recent Medicare reimbursement policies and reforms on metropolitan area safety net hospitals, and the potential impact of new policies that have been proposed by the Administration, the Inspector General, the General Accounting Office and ProPAC.

I. The Situation of Urban Public Hospitals Nationally

A. Summary of Distinguishing Characteristics

While urban safety net hospitals operate under a variety of legal structures, they share a common mission and many common characteristics that set them apart from other community hospitals. Although all of the characteristics outlined below distinguish safety net hospitals from other health care providers, it is their open doors for the medically disenfranchised that make these hospitals particularly vulnerable to federal budget deficit reduction amendments.

Safety net hospitals provide a significantly higher volume of inpatient and outpatient services than their private sector counterparts; they have seen increases in occupancy rates while the hospital industry in general has seen occupancy rates fall. They provide many unprofitable specialized services. For example, according to a National Association of Public Hospital (NAPH) survey, NAPH hospitals are three times more likely to be designated a trauma center than private facilities. Many inner-city trauma centers provide a high proportion of uncompensated care associated with gunshot-wound victims and other victims of violent crime. The cost of such treatment is high and, most often, patients have no insurance or other means to pay for it.

These urban hospitals are major educators of our nation's physicians and nurses. They are funded to a much greater degree than other hospitals by

governmental sources (local, state and federal), and thus are more vulnerable to state and federal government policies and budget issues.

Urban public hospitals are treating a disproportionate share of the AIDS population, both inpatient and outpatient, and that burden is increasing. Preliminary data from 1987 indicate that the percent of Medicaid payments has decreased to 54%, and the self-pay/other sources of financing have increased to 33%. Private insurance represented 9% of admissions and Medicare was up very slightly to 2%.

The effect of the current nursing and manpower shortages on metropolitan area hospitals is sufficiently important to merit a day of hearings itself. Suffice it to say here that it is becoming increasingly difficult for urban public hospitals to compete for manpower with private sector wage increases and bonuses. The types of patients we serve and the level of services we provide also hinder recruiting efforts. (These factors apply to recruitment of physicians and other health professionals, as well as nurses.)

III. Proposed Changes in Medicare Payment Policies

The President's budget calls for further cuts in payments to teaching hospitals and in capital cost reimbursement. In addition, the Inspector General of the Department of Health and Human Services called for elimination of the disproportionate share adjustment in a report issued last May. I would like to address these issues and the problems that would result if such changes were made.

We believe the cumulative effect of various reforms undertaken by both public and private payers in our nation's health system today puts "safety net" hospitals in particular jeopardy. We do not believe the health system can easily afford to give up our hospitals at the time of great instability. The members of this Subcommittee have understood this fact for the last several years, but unfortunately the Reagan Administration and many state governments did not.

Your increased attention of these matters over the last several years has been essential, because substantial changes in public and private reimbursement systems -- ranging from the Medicare prospective payment system to the growth of HMOs, PPOs, and other alternative delivery systems -- have significantly increased the pressure on "disproportionate share hospitals." The "cost shift," which had previously served to help stabilize care for uninsured or underinsured patients, for all practical purposes is disappearing in the face of strenuous demands by all payers for cost containment. In our rush to contain costs and curb hospital inflation, we must recognize that not every cost previously shifted was due to inefficiency or waste. Many such costs are legitimate, including the costs of providing so-called "uncompensated care," the costs of educating future generations of health care professionals, and the costs of biomedical research and essential preventive and primary health services. Yet even those essential services are increasingly being left by our system to be borne by local governments, by taxpayers, by "disproportionate share hospitals," by the low income patients themselves, or by no one at all.

A. Medical Education Adjustments

The President's budget contains proposals to reduce the Medicare payment adjustment for the indirect costs of graduate medical education ("IME"). The adjustment would be reduced from 7.65% to 4.05%. The General Accounting Office ("GAO") also has opined that the indirect medical education adjustment is too high. The GAO recommends that, without changes to the cost factors considered in calculating the adjustment, the indirect medical education adjustment should be set at 5.09%, if the costs are measured more accurately.

GAO fails to recognize the broad purposes behind Congressional enactment of the IME payments. The House and Ways and Means and Senate Finance Committees described the rationale behind the IME adjustment as follows:

"This adjustment is provided in light of doubts . . . about the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents . . . the adjustment for indirect medical education costs is only a proxy to account for a number of factors which may legitimately increase costs in teaching hospitals.

Senate Finance Committee Report, No. 98-23, March 11, 1983; House Ways and Means Committee Report, No. 98-25, March 4, 1983.

The Association of American Medical Colleges ("AAMC") recently analyzed the impact of the various types of PPS payments on hospital margins and the effect of cutting the indirect medical education adjustment from 7.65% to 4.05%, as proposed by the President. The AAMC found that the DRG rate does not recognize important differences in hospital costs, including the range of services offered by teaching hospitals and the socioeconomic mix of their patients. According to AAMC's analysis, a 50% reduction in the indirect medical education adjustment would reduce average PPS margins of teaching hospitals from positive 5.3% to negative 5.2%.

AAMC analyzed financial data from 65 hospitals which are members of the AAMC's Council of Teaching Hospitals. Average PPS margins for these hospitals dropped from 18.6% in 1986 to 5.3% in 1988. In 1988, 19 of these 65 hospitals had negative margins; in 1986, only 2 of 55 reporting hospitals had negative margins. AAMC also found that, for these hospitals, the IME and disproportionate share payments constitute a significant portion of their total PPS payments -- on average, about 25%.

As with PPS margins, there is a downward trend in total hospital margins between 1986 and 1988. For the 65 responding hospitals, 1988 total hospital margins were one-half their 1986 level, down to 3.1% in 1988 from 6.2% in 1986.

ProPAC has conducted its own analysis of the indirect medical education adjustment in making its fiscal year 1990 recommendations to the Congress. ProPAC monitors the financial impact of lowering the adjustment for teaching hospitals and the overall financial liability of these institutions. In addition, ProPAC considers equity in the distribution of PPS payments in making its recommendations. ProPAC estimates of fourth year PPS margins show a dramatic decrease from its estimates for the initial 3 PPS years. ProPAC also reports that major teaching hospitals have lower total margins when compared to other teaching and non-teaching hospitals. According to the ProPAC analysis of 1987 hospital financial data from the American Hospital Association annual survey, the total aggregate margin for major teaching hospitals was 2.5%, compared with the total margin of 4.2% for non-teaching hospitals.

Perhaps most significantly for our purposes today, ProPAC concludes that:

Lowering payments to teaching hospitals should be waived in light of the impact such action would have on the quality of and access to care for Medicare beneficiaries.

ProPAC, Report and Recommendations to the Secretary, March 1, 1989, P. 40 (emphasis added).

As ProPAC states, in urban public hospitals such as the hospitals which I oversee, the teaching program creates access to care for the uninsured. Our residents are the family physicians for the un- and under-insured of Alameda County. Reduction in support for our teaching program equals reduction in access to care for our constituencies.

Moreover, the impact of reductions in indirect medical education payments may be exacerbated by changes in the reimbursement methodology for the direct costs of medical education. Since the Health Care Financing Administration only recently issued proposed regulations implementing this

statutory change, the impact of the new payment methodology is not yet clear. Thus, to avoid the potential for totally unmanageable financial distress, it may be wise to postpone any changes in the reimbursement for indirect medical education costs.

Because teaching hospitals receive IME payments according to their individual resident-to-bed ratios, hospitals with relatively high resident-to-bed ratios have experienced a greater percentage reduction in their IME payments than hospitals with lower resident-to-bed ratios. Reductions in IME payments penalize disproportionately those hospitals which bear a greater proportion of the nation's medical education load.

In summary, reaching a truly accurate figure with respect to the indirect costs of graduate medical education involves a complex interaction of variables (such as case-mix, location, and the effects of outlier and disproportionate share payments). I will not venture to suggest that a specific figure is correct or incorrect. Rather, I will assert simply this: metropolitan area public hospitals cannot withstand cuts in medical education payments without compensating adjustments elsewhere in the Medicare reimbursement scheme.

B. Capital Payments

In OMRA 1987, Congress reduced payments for capital costs by 12% (below costs) as of January 1, 1988, and by 15% in FY 1989. In FY 1991 the Secretary of Health and Human Services will be required to incorporate capital payments into the prospective payment system. The President has proposed that capital costs be reduced more drastically in FY 1990 -- to 25% below costs. While the impact of these reductions would not be as great as that resulting from cuts in indirect medical education reimbursement, they are still significant for urban public hospitals.

Metropolitan public hospitals have special concerns regarding capital cost reimbursement because the average age of their plants is significantly greater than that of other hospitals. Capital improvements, including modernization of equipment, have been unaffordable to most urban public hospitals. Because of their relatively low level of privately-insured patients, as noted above, such hospitals are uniquely reliant on governmental payors in their effort to gain access to capital. Yet it is this very same reliance that makes it so important that needed renovations and improvements be made. Thus, I urge you to keep the situation of these hospitals in mind when considering any changes in the reimbursement for capital costs.

C. The Disproportionate Share Adjustment

The disproportionate share adjustment has been essential for our nation's urban public hospitals, and has been an effective way to target Medicare funds where they are needed most. There is no doubt that these hospitals are deserving of this adjustment, in support of the vital role they play in caring for the nation's low income elderly and other poor, and in providing essential specialized services to all citizens.

I am pleased that your subcommittee took the lead last year in convincing the Congress to reaffirm the importance and validity of the disproportionate share adjustment, by deleting the 15% cap on payments and extending the expiration date until October 1, 1995. Although the Congress thus already has rejected the Inspector General's recommendation to allow the disproportionate share adjustment to expire, I would like to take this opportunity to point out two serious flaws in the Inspector General's report.

First, in conducting the audit on which his conclusions are based, the Inspector General used data that were seriously out of date. Second, unlike ProPAC, the Congressional Budget Office, and other observers, the Inspector General looked only at Medicare costs and expenditures -- and not at all at the costs associated with Medicaid and uninsured patients, which are an essential part of the disproportionate share adjustment equation.

As the total financial situation of metropolitan safety net hospitals continues to deteriorate, we would strongly urge you to consider a further

increase in the disproportionate share hospital adjustment, at least for those hospitals whose problems and needs are the greatest.

IV. Illustrations

In this section of my testimony, I would like to illustrate the general characteristics and observations set out above by describing the current situation in California and Alameda County.

A. Situation in California

As providers of two-thirds of California's hospital care to the uninsured, California's public hospitals have borne the brunt of public and private sector cost-cutting measures -- measures which increased the numbers of the uninsured, and decreased the extent of coverage for many who are insured. California's 31 county hospitals, comprising only 11 percent of California's beds, provided 83 percent of the state's charity care in fiscal year 1987-88. Even if one recognizes 50 percent of statewide bad debt as under-reported charity care, the counties' share remains a remarkable 66 percent. California's county facilities dedicate 32 percent of their operating budgets to uncompensated care (total charity and bad debt), as compared to only 3.4 percent, 3.1 percent and 3.5 percent, respectively for non-profit, investor-owned and district hospitals.

At the heart of the state's health care safety net, counties are deeply committed to effective resolution of the growing crisis in meeting the needs of the 5.2 million unsponsored Californians. As this Subcommittee begins the inevitable deficit reduction debate, it is critical that the impact upon public hospitals is accurately projected so that resources are preserved to support their safety net role.

In recent years, public hospital managers have seen their fears confirmed regarding the impact of economic forces on the health care objectives to which they are committed. While the jury is still out regarding the effects of competition on containing health costs, its predicted effects on unraveling the health safety net are quite evident. Major indigent care providers have lost profitable privately-insured patients. Core safety net providers, such as California's county facilities, have been filled to capacity with the unsponsored patients who have found private sector care available to them only in a true emergency. As a result, the county hospitals' already overwhelming share of the state's uncompensated care burden has risen 27 percent since the initiative of California's "competitive" reforms -- limited only by capacity, nursing supply and inadequate resources.

California's public facilities can withstand little more of the crosswinds of government underpayment and private sector competition. While the increasing interest of all parties in the state's unsponsored crisis is encouraging, consensus on appropriate solutions will require more time than our beleaguered facilities have available. If interim steps are not taken to protect the safety net, the health care house of cards will come down -- endangering thousands of lives.

Almost without exception, providers of "disproportionate" levels of uncompensated care carry high Medi-Cal loads. Congress has acknowledged the importance of providers of disproportionate levels of Medicaid and low income care by requiring specific payment adjustments and, most importantly, by exempting state payments to these providers from the payment limits that apply to all other providers. As a result, many states have leapt at the chance to make cost plus payments to disproportionate share hospitals, with the federal government footing 50 percent or more of the bill. Aggressive states have been able to assist key providers in meeting the needs of the sponsored and unsponsored poor by eliminating the drain of Medicaid underpayment.

Bills introduced in the California legislature attempted to move in this direction. However, the level of funding available, as well as delays in the distribution of the funds, have brought disappointment. County hospitals recorded \$237 million in Medi-Cal losses in 1987-88. Some of the gaps need to be closed to improve woefully inadequate physical plants and staff and technological deficiencies.

To illustrate the pressure now brought to bear on California's urban safety net, I would like to describe the situation in my own Alameda County, and in Los Angeles County.

B. Alameda County

The hub of the Alameda County health care system is Highland General Hospital, a general acute care facility located in central Oakland, was first opened in 1926 as an acute care hospital for medically indigent patients. It gained its reputation as a major teaching hospital during the 1930s and 40s. Highland Hospital remains the essential provider of acute in-patient services for the County's medically indigent population. In addition to general medical and surgical services, the hospital offers a broad range of specialty services, including perinatal care, and obstetrics and neonatal services. Highland also provides Alameda County with acute psychiatric in-patient and emergency care, and was recently designated as the trauma center for northern Alameda County.

Most of Highland's patients live in the low-income areas of Oakland. Reflecting the general health pattern of low-income, urban communities, the hospital's patients are sicker, have more complex medical problems and require more treatments, medicines, nutritional care, monitoring, respiratory aids, education, and social support than the general population. Only two percent of Highland's patients are referred by private physicians; 75 to 80 percent of all admissions come through the emergency room, usually during the evening or at night. Roughly 22 percent of our patients have been referred by private hospitals, clinics, or social services agencies. Sixty-four percent of our patients are self-referred, and 12 percent are brought in by law enforcement agencies or arrive by ambulance. Highland operates at 90 - 100% occupancy of available beds (due to inadequate resources and staff, not all licensed beds are available for patient care).

The second public hospital in our system is Fairmont Hospital. Fairmont is primarily a 300 bed skilled nursing facility, with some rehabilitation capacity and a small back-up acute care unit. Fairmont operates at near 100% occupancy.

Urban issues -- AIDS, drug abuse, homelessness, violent crime -- plague the Agency. Alameda County delivers only 4-5% of all babies born annually in California, but delivers the 25% of California babies which are born with congenital syphilis. Over 40 drug-addicted babies are born in Highland each month, and we are not the primary high-risk delivery facility in the County. Alameda County has the fourth largest AIDS population in the state. In the winter, we often serve as a shelter for the homeless.

The capital needs at both county hospitals are enormous. We estimate a \$70 million need for maintenance of Highland's existing plant and a redesign of its clinics and emergency care space, which is needed to handle the existing patient load; this estimate does not include costs of expansion of our inpatient capacity. Fairmont is long overdue for physical plant renovation; this facility is not yet air conditioned.

Demand for services at Highland has risen dramatically during the last 8 years. Total admissions (including psychiatric) for fiscal year end ("FYE") 1981 were roughly 9,245. By FYE 1985 we admitted roughly 11,500 patients, and for FYE 1988 our total admissions were roughly 13,500 -- a 46% increase since 1981. We project 14,500 total admissions for FYE 1989. During the same time, the average length of stay dropped dramatically from 7.0 days for FYE 1981 to 5.0 days for FYE 1988.

Our total outpatient visits have also risen dramatically. From 1981 to 1988, the numbers of outpatient visits we provided rose nearly 24% (from 120,062 to 148,270). In the last year alone we have seen a substantial increase in clinic visits. In November 1987, Highland Hospital provided 5500 outpatient clinic visits to the residents of Alameda County; in November 1988 that figure was 7250 visits, an increase of nearly 32%. In March of 1989 we provided 3,000 more clinic visits than provided in March of 1988.

Our resources have not expanded as rapidly. Thus, as you might expect, the average waiting time for clinic visits at Highland has risen dramatically. Between April 1987 and April 1989, the average waiting time for a new appointment to our chest clinic rose from 5 weeks to nearly 13 weeks. During the same time, the waiting period for new clinic appointments to our dermatology clinic rose from four weeks to 13 weeks, for our renal clinics from five weeks to 10 weeks, and our neurology clinics from three weeks to 7 weeks. As of April of this year, the average wait for a new appointment in our ear-nose-throat clinic was six weeks, and for return appointments the delay was four weeks. For ophthalmology, the current wait for a new appointment is now two months, and three weeks for a return visit. A simple refraction may entail a three month delay. At present, bed availability can be delayed as much as 20 hours or more, and wait time for an emergency appointment can exceed six hours.

To improve the quality of care, our goal is to improve facilities and staffing so that clinic appointments are available within one week, no emergency room patient must wait longer than two hours for a noncritical visit, and there is no wait for bed availability when an admission is required. We estimate that, these quality of care improvements would cost approximately \$77.7 million. According to our calculations, we can expect these improvements to generate approximately \$25.8 million in new revenues, leaving \$51.9 million net cost to Alameda County. Simply to maintain our existing standard of care and keep up with anticipated increased costs -- including cost of living increases for staff, inflation in our supplies and services budget, benefits increases, and the like -- we anticipate needing an additional \$10 million dollars for FY 1990.

I mentioned earlier that urban public hospitals carry a heavy Medicaid load; this is true in Alameda County. At Highland General Hospital, MediCal accounts for 33% of our total operating revenues. Medicare accounts for another 12%, and private insurance for only 8.6% of total revenues. Highland relies on County and other subsidies for the remaining 46.1% of our operating revenues.

In the face of the growing problems of the inner city, and in a time of limited resources, Highland operates on triage principles. Offering immediate treatment to one person always means delaying treatment to another. I have been actively working on ways to make our capable clinicians aware that, at current resource levels, each treatment decision has a consequence for other patients.

As part of these efforts, we have hired a consultant to organize and facilitate staff and physician attention to treatment decisions. As I am sure you can imagine, this has brought cries of "rationing" from observers who do not understand the existing situation at Highland. This program is not designed to institute rationing of health care -- in a strict sense, our limited resources force us to ration care every day, when we decide who to treat first, and what treatment to offer. Rather, I hope this program will help us rationalize our treatment decisions, understand our priorities, and make us more aware of the consequences of our everyday decisions to all patients.

C. Los Angeles County Health Department

A diminishing funding base and continued expanding workload demands have converged to create a crisis in the Los Angeles County health care system. Due to the progressive erosion of the Los Angeles County Department of Health Services ("DHS") funding base over the past several years, this year's recommended \$75 million "adjustment" cannot realistically be absorbed. Previous extrabudgetary funding requirements have exhausted all remaining reserves. The budget recommended for next fiscal year, if adopted, will further worsen DHS' already precarious financial position.

With continued budgetary emphasis on just barely meeting operating requirements, and given an expanding workload, DHS has accrued an enormous deferred maintenance liability in aging and heavily utilized facilities. DHS could appropriately utilize well in excess of an additional \$100 million for next fiscal year alone, in avoiding the proposed service reductions and

meeting other critical staffing, maintenance, services and supplies, equipment, and systems needs, without adding any new programs.

1. Declining Subsidies

Los Angeles County's contribution to DHS operations has declined from 16.8% of the County's total available funding in Fiscal Year 1980-81, to 10.6% for the current fiscal year, resulting in a loss of \$143 million in constant purchasing power for Fiscal Year 1988-89 alone. As a result, the current County contribution to DHS (\$246.9 million) is only \$4.9 million more than in Fiscal Year 1980-81. Further, due to the passage of Proposition 98, which guarantees certain funding levels for the educational system, the Governor proposes to reduce the Medically Indigent Services Program funding state-wide by over 70%. This would reduce LA County's current MISF allocation from \$204.2 million to \$56.2 million for Fiscal Year 1989-90.

DHS has avoided significant program curtailments only by:

- * Containing expenditures, including substantial deferred maintenance and undercapitalization of equipment.
- * Increasing revenues as percentage of net appropriations from 56.5% to 72.4% since Fiscal Year 1980-81, yielding an additional \$249 million annually in constant Fiscal Year 1988-89 dollars.
- * Utilizing one-time funding sources.
- * Increasing overall productivity over the past nine fiscal years by 11.1%.
- * Incurring administrative reductions from Fiscal Year 1986-87 through Fiscal Year 1988-89 of over 600 positions, amounting to almost \$16 million in annual expenditures.

2. Workload Trends

DHS workload has resumed its upward trend during the current fiscal year. Since fiscal year 1981/1982, admissions have increased 32%, ambulatory care visits have increased 63%, emergency room visits have increased 31%, and the number of births in DHS hospitals has increased over 79%. The recent series of emergency room and trauma unit closings at other hospitals has greatly exacerbated this problem.

3. Departmental Issues

Among the \$75 million in recommended adjustments to the DHS funding base for next fiscal year are the following items:

- * Reduction of Nursing Recruitment, Retention and Registry Funding. The national nursing shortage has not abated. Continued funding to enable enhanced recruitment and retention efforts, and to allow us to use nursing registry personnel to cope with the nursing shortage, is critically needed.
- * Inadequate/Inappropriate Cost of Living Adjustments, below recognized inflationary trends and overly optimistic revenue forecasts.
- * Other Items, including further erosion of fixed asset funding, denial of monies for expansion of AIDS outpatient and home health services, and underfunding for OM contract expenses. In addition, no provision is made for potential salary and employee benefit increases subsequent to the expiration of labor contracts on September 30, 1989.

4. Unmet Needs

In addition to the problems noted above, the DMS will remain substantially underfunded in several areas, including:

- AIDS programs.
- Outmoded equipment.
- Information systems.
- Community trauma/emergency room funding.
- Psychiatric emergency inpatient services.
- Nursing staff levels.
- Facility replacement and maintenance.
- Drug programs.
- Security at hospitals and health centers.
- Hazardous materials handling and storage.
- Communicable disease control.

V. Summary

Today, American cities are returning rapidly to a two class system of health care -- one composed of private providers competing for insured, generally health individuals and the other consisting primarily of the network of public (and a few private) hospitals serving the needs of the indigent and severely ill who have no access to mainstream medical care. I increasingly hear it said that we now have a three-tier health care system: top-of-the-line care, triaged care, and no care. All of this is being done in the name of cost reduction, competition and private entrepreneurial spirit.

In order for public hospitals to live in this new world, there must be an explicit recognition of these changes and recognition of the critical role of public hospitals. Measures must be taken to safeguard our survival and, therefore, access to health care for the nation's poor. In addition, sweeping changes in Medicare reimbursement may increasingly require us to serve the elderly as well, as they are increasingly "welfarized" by changes in the Social Security and Medicare systems. Many of my colleagues in the public hospital sector are convinced that this will occur, particularly with those Medicare patients likely to be "outliers" in private hospitals, and those who will no longer be able to afford substantially increased premiums, copayments and deductibles. As the private sector makes its business decisions only we, the public hospitals, will, to the extent that we can survive, remain to care for America's most vulnerable populations.

We remind you that these safety net hospitals are urban hospitals, serving the poor and near-poor in the largest metropolitan areas in the country. These are the providers which serve the victims of many tragic inner city problems -- AIDS, homelessness, drugs and drug-related violent crime. In a time when many hospitals are suffering from "low occupancy," these hospitals are filled to -- and sometimes beyond -- capacity.

We reiterate our applause for Chairman Stark and your cosponsors for already introducing legislation to address such critical concerns as direct support for "safety net" hospitals, the crisis in trauma care, and the adequacy of Medicaid payments. In the forthcoming budget debate, we urge you to pay careful attention to the impact of the indirect teaching and disproportionate share hospital adjustments on our most vulnerable safety net hospitals.

Chairman STARK. Thank you, David. I would like to testify to the fact that I am familiar with the problems that you face perhaps more than other hospitals around the country.

The record ought to show that one of the problems that we have is that we shot ourselves in the foot many years ago by passing legislation in the State that really does not allow us, even if we wanted to, to raise our real estate taxes to raise any money.

So we are in a real catch-22 situation. So even if the good citizens of the Alameda County wanted to raise our taxes under what we refer to as proposition 13, we cannot. It does cause an extra burden.

Can you, Dr. Boufford, answer this? It has been said that your length of stay is so much higher than the average that if it were the average, you would actually have less of a critical occupancy problem. What drives your length of stay?

Dr. BOUFFORD. Our length of stay has gone up about a day, which is not atypical in New York. New York hospitals have had a longer length of stay than other hospitals in the country. We think it has to do with severity of illness. Our patients with drug morbidities and our AIDS patients have an average length of stay of about 21 days. As the numbers of these patients go up, it drives the overall length of stay number up.

The bias in the length of stay tends to be attributable to a few patients who stay a very long time. These long-stay severely ill patients jam up beds that could be available otherwise. Part of the problem in New York is that until 2 years ago there was a moratorium on long-term care construction. We are behind the 8 ball now, with predictions of a need for 7,000 long-term care beds in New York City alone. It will be years before projects in the construction pipeline are completed and, in the meantime, patients will experience delays in appropriate long-term care placement.

Medicaid reimbursement for outpatient services has been capped at \$60 a visit for 10 years. There has been no incentive to develop resources on the pre-hospital or post-hospital side.

Chairman STARK. If we provide higher Medicare funding, how do we know that the States won't just cut back an equal amount? Is that apt to happen? That is a concern we have here.

It has happened to us in California. Governor Brown was just about as bad as Deukemajian. We raise one payment or another, and California and New York are the two most generous States. With all due respect to our taxpayers, every time we bump up the Federal payments, the States want to reduce their share so they can spend it on something else they need.

Dr. BOUFFORD. We have just had a battle in New York State over proposed cuts in the Medicaid program. The State legislature reversed a number of the proposals. More people have fallen off the rolls from the point of eligibility, although there is some effort now, especially for women and children, to enhance the benefit.

I would say in New York, we have not seen the use of Medicare to allow a cutback in Medicaid because it has been, as you pointed out, a more generous State in terms of health policy.

It essentially subsidizes the hospitals for inadequate Medicaid reimbursement in many instances, to the degree that they can operate efficiently.

Chairman STARK. We are hearing a lot and perhaps you can help me in a letter at a later date, if you would, but we are constantly hearing about reimbursement plans under part B. People say, oh, but are you aware of what goes on in Canada?

I am, but it is generally brought to us that people wait 60 or 90 days to get a hip replacement. I think you both testified, but you may have some figures on how long people wait in New York and Oakland hospitals for a variety of procedures and what the experience has been.

I think you are right; we ration in this country, at least I am told in Canada the rationing is clinically driven. The doctor decides maybe we should not do the cataract surgery now or the hip replacement, it can wait. Whereas in New York and Oakland, there is no rhyme or reason, we are out of money, and there is no room at the inn.

Mr. KEARS. It is like a lottery system, and people wait or people get it without any fairness. If neither the Federal or State governments as a whole are going to put massive amounts of money into the health care system, then its only alternative is to look at how you spend what you have and see that more of the critical and prevention care gets funded.

You have to accept the fact that some things are not going to happen. Now, is there any policy as to what does or does not happen? I am not sure there is, other than people want to wash their hands and not take responsibility.

If you take responsibility, one or two things will happen. Either you will make a more rational system or what you will do is decide that you cannot live with the fact that you don't spend more money and you will spend more money, and you will get public support for it.

There are issues out there in which the public is willing to spend more dollars. In our country, we have had health issues that got 7 to 8 percent of the vote. It just means that we have to be more focused, and there has to be a benefit seen to the public. I contend that we are not going to get anywhere unless we deal with major changes in new money or major reform of the present system.

Dr. BOUFFORD. One of the biggest concerns about the issue of rationing is that there are so many people who don't have access in the first instance, so we don't know that they are not getting the service they need.

We have done studies in New York showing that the identification of cancer in the minority population is way below what it should be. They come in very late, almost terminally ill. And there is a whole host of diseases where people don't even come in to be diagnosed.

Chairman STARK. I have heard some physicians with a great social concern and interest in helping us, particularly in the inner-city parts of my district, suggest something when I might say that we have an obscene infant mortality rate in Oakland. I have heard casual comments from physicians that those people would not even go to the doctor if they had insurance.

I think that's cavalier, if not somewhat insensitive. Do you find somehow that people are unaware of the benefits of getting health

care? Is there something that poor people that either of your hospital systems represent that don't want health care?

Mr. KEARS. You have to look at two parts. There is a sizable percentage of people who find the current system so frustrating, they have given up on it. The only way the welfare and health care system survives is putting enough barricades up so that most people who use the service never make use of it.

There is another part. Lifestyle plays a part, crack, cocaine and other drugs, when you talk about changing the system. You are not just talking about changes in reimbursement but also delivery.

The question is can we afford to let someone ignore their health care and deliver a baby that we will care for for the next 50 to 70 years? I say we cannot.

Can we as a society afford that cost? I don't think we can. We have to look at not just reimbursement mechanisms, not the disproportionate providers or can we and must we deliver services differently? We will pay for that care one way or another.

Dr. BOUFFORD. Just to support that, I think the model of care is so important, especially in helping people negotiate these enormous hospital institutions which have become the family doctor for the inner-city resident because private physicians cannot afford to be in practice any more.

We have been able to develop a model for a very effective case management of IV drug abuse AIDS patients which nobody thought was possible. In fact, you can develop a model that is appropriate in the community, where there is a trust level, and the family support systems, such as they are, can be mobilized.

I don't think any of us would want to negotiate an outpatient department as our source of care, and we cannot expect others to do so, either.

Chairman STARK. Thank you very much for your somewhat depressing but very helpful testimony today.

Our next witnesses are a panel of experts on rural health care: Dr. Philip Caper, president of the Codman Research Group; James D. Bernstein, chief, Office of Health Resources Development, North Carolina Department of Human Resources, Raleigh, NC; and Steven Rosenberg, president, Rosenberg Associates.

Welcome to the committee. We will ask you to present your testimony in the order you are listed on the witness list.

Dr. Caper.

STATEMENT OF S. PHILIP CAPER, M.D., PRESIDENT, CODMAN RESEARCH GROUP, INC., LYME, NH, AND PROFESSOR OF PUBLIC POLICY, DARTMOUTH MEDICAL SCHOOL, HANOVER, NH

Dr. CAPER. If I can ask the chairman's permission to depart from the normal procedures followed, I would like to use transparencies to make a few of these points.

In response to the interest of the committee, we have prepared some slides to show you a little bit about the study we have done.

This map, as you will see, is a map of the United States. What we have done is to take the Medicare system and divide the country into about 4,800 possible market areas and have then per-

formed detailed measurement of the utilization and cost of medical care among the entire Medicare population.

The relevance of this study to the topic at hand is that the Federal care system is now being provided with an extensive and detailed data base which will allow you to answer many of the questions which the committee has posed this afternoon.

It is essentially an ongoing monitoring system, a look in detail at the way the Medicare system functions. Our role was to provide an analysis which looks primarily at the beneficiaries of care rather than primarily at the institutions. So it complements the already excellent information you have about what is happening to specific institutions by telling you a little bit about what is happening to the beneficiaries being served by these institutions.

This map is a computer-generated map showing the rates for hospital services for medicare beneficiaries living in each of the 48 contiguous States. As you can see, beneficiaries living in the States colored in the salmon color, such as Pennsylvania, Alabama, and Mississippi, have about double the chance of being hospitalized as those living in the states which are green, including Oregon, which has a low utilization rate; California, which has a utilization rate somewhat above Oregon's but about halfway in the distribution.

There is a fair amount of variation in the probability of a Medicare beneficiary being hospitalized. These rates are all population based. The hospital event is counted against the patient's place of residence, not where the care took place. So we are looking at the probability of admission to hospitals as a function of where the patient lives.

There is a great deal of variation throughout the country. The variation within States is even greater than the variation among States. When we see a twofold variation between States, then those causes of admission may vary fourfold or more within States.

This shows variation and utilization for surgical causes of admissions which is slightly less, about 1½-fold.

The data is diagnosis specific. Here's a graph showing the same information for a specific surgical cause of admission. A resident of Utah, for example, has about 10 chances in 1,000 of being hospitalized for major joint operations; and residents of New York have only 4 chances in 1,000.

There is a 2½-fold variation between Utah and New York in being hospitalized for major joint replacements, mostly hip. This graph shows the same data expressed as a percent of the national average.

The residents of Utah have a 70 percent greater chance of being hospitalized for hip surgery than the national average. In New York, they are 70 percent of the national average. So, there are large variations in the probability of being hospitalized for specific procedures.

The reasons underlying these variations are twofold. One has to do with the fact that these populations are different from one another. Some people will have more hip illnesses than others. We think the most important driving factor is the decisions physicians make, so the physicians in Utah are more likely to recommend surgery than physicians in New York, et cetera.

This again is a map showing the distribution of major joint surgery by State. You can see New York has a relatively higher probability of joint surgery than do California or some of the Western States. I will pass over the rest of this fairly rapidly.

There is also variation in the length of stay. A New York resident stays about 46 percent longer than the average American for hip surgery, and Utah residents have about 70 percent of the national average length of stay for the same operation.

This next map describes the dollars per admission. There is a fair amount of variation, about twofold in the charges per admission for the same operation based upon the patients state of residence.

Similarly, these are the dollars per admission calculated as a percent of the national average. So in California, the average charge for admission for major joint surgery is about 24 percent above the national average, and the average charge for admission in Iowa is roughly equivalent to the national average.

The California admission rate is also significantly higher than the national average for major joint surgery which is average in Iowa.

The charge in California is high, and the charge in Iowa is average. This shows the range for nonsurgical causes of admission. That tends to be larger than the range for the surgical.

These variations in admission rates for surgical causes have had a lot of attention, but the medical causes are more variable than the surgical. In this case, there is over a twofold difference in the probability of admission for a medical cause of admission depending on the patient's place of residence.

Here is a medical cause of admission, pneumonia. Variation is threefold. In California, the probability of admission falls between 9 and 12 cases per 1,000 residents.

In some of the other States, Tennessee, the rate is 18 to 21 cases per 1,000. This is a highly discretionary medical cause of admission. A lot has to do with the perceptions of the physicians as to what appropriate use of the hospital is.

Here is a case suggesting the applicability of this technology to look at environmental influences. This shows admissions for lung cancer as a function of place of residence.

There is a cluster of States in the Southeast where admission tends to be high for lung cancer. Ordinarily, this is a low variation, nondiscretionary cause of admission.

Most physicians faced with a case of lung cancer will hospitalize that patient during some point in their illness. These States happen to coincide with States EPA has found have toxic air emissions.

Here is an example in the State of Pennsylvania where the causes of admission are higher than the national average. This graph shows you the specific uses of the hospital by residents of Pennsylvania. All of these case types—causes of hospital admissions—are above the national average rate for residents of Pennsylvania.

Here is an example of a State below average admission, only 7 causes are above the national average.

This is Minnesota where the use of hospitals in general is below the national average. This is important because we now have the capability to not only say the admission rate in Minnesota is low or in Pennsylvania is high, but to look at the specific ways in which those hospitals are being used.

It gets to some of the questions that subcommittees asked earlier about the case mix shifts in rural versus urban hospitals. We will show you some examples now taken from some of our statewide all-payer analyses. The data I just showed you is Medicare data.

This data is from public access statewide analysis. This shows you how our hospital market areas are constructed. They are constructed around two or three dominant hospitals which serve that population.

Once the market area has been constructed, we measure all the care provided to the residents of that market area whether it is provided locally or in a remote hospital. That allows us to trace what is happening to residents of areas so we can begin to measure whether access to care is being impaired.

This is a time line on a computer-generated screen showing a number of market areas in California. You can see that the hospital market area called Gridley has the highest admission rate among them.

In general, these rural hospital market areas tend to have higher than average admission rates and have for many years, and probably that is because of the relatively higher availability of hospital beds because of Hill-Burton and other Federal initiatives.

The rate tends to be declining and converging around the State average. Nevertheless, they remain at about the average Californian's rate of admission. That says that even though some of these smaller hospitals are closing, there does not seem to be an access problem created. Those patients are probably just going some place else.

Here is a bar graph again showing that the average resident of the Gridley market area is hospitalized at 15 percent above the California rate; residents in about 8 out of 10 of these areas, still the residents, are being hospitalized at above State average rates.

This shows us—this is again similar data for Washington State which shows the same kind of picture. Most of these areas are experiencing hospitalization rates at above the state average rate.

That is also true for the residents of the third State we examined, which is Iowa. Based on a preliminary examination of the data—and we are intending to do a more extensive and systematic study for ProPAC of this problem—based on a few areas, it seems access is not being impaired by difficulties of these small rural hospitals.

Again, this shows us that Metaline Falls has a higher rate. These areas that are declining are not declining much more rapidly than the State average is.

The second point is that the case mixes seem to be changing. I would like to call your attention to page 8 of the Winn testimony. On page 8, there are tables showing the reason for hospitalization and the hospital destinations by case logs. This shows us that these rural hospitals seem to be losing the technically intensive cases.

Look at Glen General Hospital in northeastern California; for all causes of admission, 48 percent occurred at the Glen General Hospital, and the remainder went someplace else.

Look at coronary bypass, major joint operation, chemotherapy, none went to Glen General Hospital. In fact, those cases went to relatively nearby but more sophisticated institutions.

The same is repeated in Washington State and in Iowa. The effect of that has been a change in case mix, leaving these hospitals with the common medical conditions of pneumonias, chest pains, heart attacks, and losing the surgical cases.

Many of these complex situations tend to be covered by insurance. So the small hospitals have been losing their share of private insurance patients, leaving them with Medicare and few other places to cost share their expenses. That is happening in every hospital like this we have examined so far.

The result of that has been to find the hospitals are losing market share for dollars faster than market share for admissions. Even though admission rates are declining, admission rates for dollars are declining more rapidly because lucrative cases are leaving for other places.

Chairman STARK. What is putting the pressure on them to say they want the severity index? If they get the severity cases, it will not help them, will it?

Dr. CAPER. We are not talking about the small rural hospitals.

Chairman STARK. But you are showing us that that is not the case, that they are getting the more pedestrian cases.

Dr. CAPER. They are losing the lucrative cases.

Chairman STARK. You can be severely ill with pneumonia and have to stay in the hospital for a week, but that doesn't pay you big bucks.

Dr. CAPER. That is right.

Chairman STARK. So severity is not complexity.

Dr. CAPER. That is right. It is the lucrative cases that are going elsewhere and mostly to the nearby regional centers.

Chairman STARK. Is that related to the availability of specialists?

Dr. CAPER. It would be, and the larger hospitals are able to support larger, more intense technology than the small rural hospitals.

I would like to say a word about the inner-city problem. In the inner-city areas, we have done studies in New York, Los Angeles and the District of Columbia, and we found in general residents in inner-city areas tend to use hospitals at a much higher rate than the residents of these areas as a whole.

The causes tend to be related to higher morbidity levels. They are probably sicker populations, but they are not receiving care in time to prevent longer hospitalization. With better insurance and so on, you would probably prevent a lot of hospitalizations in these areas.

Many causes are related to the social causes in these areas, as well. This population based approach which looks at the beneficiaries we think provides valuable information which cannot be gleaned from other sources.

[The statement of Philip Caper follows:]

Testimony of
Philip Caper, M.D.,
President of the Codman Research Group, Inc.,
Lyne, New Hampshire 03768

and

Professor of Public Policy, Dartmouth Medical School
Hanover, New Hampshire

before the
Committee on Ways and Means, U.S. House of Representatives
Public Hearing on Fiscal Year 1990 Budget Issues Relating to
Payment of Inner-City and Rural Hospitals under Part A of the Medicare Program
May 15, 1989

Summary

The Codman Research Group has recently completed a small area analysis of hospital utilization for the entire Medicare population for the years 1984-86. Using similar data drawn from three of our statewide public access database analyses (for the total population in those three states), we have made a number of observations relevant to the committee's concerns about rural hospitals, based upon a small number of examples drawn from Northern California, Washington state and Iowa.

First, overall hospital utilization rates for the residents of these rural communities are often above statewide averages. Although those rates have been declining in recent years, they remain at or above statewide averages. This observation does not substantiate the view that access to hospital care for residents of rural communities is being abridged by the difficulties being experienced by some rural hospitals.

Second, the clinical mix of cases appears to be changing over time in some of these small rural hospitals. Surgical and technology intensive cases are apparently being drawn from small rural hospitals to regional referral centers, leaving the small rural institutions to care for "low tech", relatively common and predominately medical conditions.

One effect of this change in case-mix is to leave rural institutions with a disproportionately high share of Medicare patients relative to private pay patients.

The overall effect of these two interrelated phenomena is to cause these small rural institutions to lose their market share of payment dollars even faster than they are losing their market share of patients. This observation may go a long way toward explaining the financial difficulties faced by these small, rural institutions.

We are about to undertake a more comprehensive and systematic study of the problems of rural health care under contract to the Prospective Payment Assessment Commission. If the findings of this preliminary analysis hold true in that study, important policy questions concerning the future role of small rural institutions in the American health care system, and the role of the Medicare program in helping to shape that future role, are raised.

Introduction of the Prospective Payment System in 1984 was but one of many changes affecting the health care industry during this decade. Prior to implementation of PPS, hospital use rates had begun to decline throughout the United States, although it appears that much of the volume lost in in-patient care has been more than replaced by equivalent services delivered in the out-patient setting. During this period, several acute care, short stay hospitals have closed, both in urban and rural areas. Recently, concern has been expressed that the closures and financial uncertainties of hospitals in rural areas have abridged access to health care for the local residents, who could be left either with no services or a need to travel long distances both for emergency and routine care.

Population-based analysis provides a perspective on access and utilization rates that is missing from conventional hospital-based studies. It focuses primarily on the populations being served rather than on the institutions per se. The Codman Research Group, Inc. specializes in population-based analyses, and in a particular application of population-based studies called small area analysis.

Small area analysis is one method of measuring and comparing the use of medical care by defined populations. It uses statistical techniques adapted from classical epidemiology, such as adjustment for age and sex and for random variation, to compare one group's experience with another. The information is part of a general attempt to help in understanding the relationships in medical care among access, volume, cost, and quality.

Small area analysis is population-based because it looks at the total health care experience of all members of specific groups, or residents of specific areas – for example, all residents of a state, all Medicare beneficiaries, all Blue Cross and Blue Shield subscribers – regardless of where services were received. In small area analysis, however, a "service" or "market" area is defined so that residents receive more of their care from local providers than from any other source.

All residents' care is included in the generation of per capita admission rates. Because the contributions of each hospital providing care to residents are documented, one can also examine the influence of out-of-area providers on local rates, particularly for a specialty service such as cardiovascular surgery where a relatively few medical centers generally serve a wide geographic area. Graphs 1 and 2 illustrate the construction of hospital market areas based on the patient's residence and the application of this information within the context of population-based analysis in the state of Washington.

CRG has just completed this type of population-based analysis for the entire Medicare population for the years 1984-86. We have measured the per capita rates of utilization and charges for hospital care for Medicare beneficiaries throughout the United States for the years 1984-1986. The project was funded by the Health Care Financing Administration's Health Standards and Quality Bureau. I call it to your attention in this testimony because it represents a potentially valuable resource to the Committee for examination of differentials in the volume and costs of care received by beneficiaries throughout the United States, in rural as well as urban areas.

To be responsive to the Committee's expressed interest, I would like to show a few examples from that study to suggest its scope and content. Patient destination studies at the zip code level resulted in the definition of more than 4,800 distinct hospital service areas. We then generated age- and sex-adjusted rates of admission, patient days, dollars per capita, average lengths of stay, and average charges per case for each of 161 DRG-based clinical categories. Then we documented patient destinations, by case mix, for each of the approximately 4800 hospital market areas defined for the study. Population-based rates of Readmission and of Mortality were also generated in this fashion.

Utilization rates were standardized first to each state's own Medicare average, then to the national Medicare average to create consistent criteria for comparing utilization patterns between areas in different states. The results of the analysis for each state have been provided to each Peer Review Organization, embedded in a combination computer-based display and database management package we call SAMGRAPH. Working with the American Medical Review Research Center, PROs in twelve states have been provided additional funds to identify and interpret the sources of variation locally, using this extremely accessible database, and to determine how systematic applications of population-based studies might improve the peer review process.

These slides from the national Medicare study indicate greater ranges of variation among admission rates for Medical Conditions than for Surgical Procedures. The range of variation within states is much greater than the difference between states. Even with that caveat, these examples suggest that regional patterns, not only for admission rates but also for length of stay and charges, are stronger than rural-urban differences.

The Codman Research Group expects to make a systematic examination of the impact of declining hospital occupancy rates on utilization patterns of rural Medicare beneficiaries, as part of a study for the Prospective Payment Assessment Commission (PROPA²), which we hope to complete within the next several months.

In response to the Committee's interest, however, CRG has made a preliminary examination of some of these issues using existing public access statewide databases for California, the State of Washington, and Iowa. Some interesting trends and questions are emerging from these preliminary data, which are taken from statewide studies inclusive of all payors and all age groups.

The issues are complex and answers required a wide range of information integrating hospital-specific data and population-based perspectives. Although the dialogue on some of these issues is already contentious, we believe the population-based perspective can help resolve questions about access and under-service, and lay out the more subtle dynamics of technological and economic forces at work.

First, what has happened to per capita admission rates among the residents of the communities in which these hospitals are located? We find that admission rates in most rural areas historically are higher than their own state averages, even after age and sex

adjustment. Although the admission rates have been declining through the decade, the tendency is toward convergence around the state average.

The four-year trend for 10 Northern California communities is illustrated in Graph 3. Six of the ten have admission rates, excluding maternity-related care, which are significantly high relative to the California state average, while three are slightly below the average. Overall, the trend through the period is toward convergence around the California state average. Gridley's admission rate is 15% above the California average (Graph 3a), Chico's is 8% below. Graph 3a shows the same data for the year 1966 expressed as an Observed/Expected ratio, where Expected is the California state average adjusted for any differences in the age and sex composition of each area's population. The admission rate for the area labelled "Rural," a composite of the 10 individual rural communities, is 5% above expected, statistically significantly high.

Graph 4 illustrates the three-year utilization trend among rural areas in the state of Washington, Graph 4a the Observed/Expected ratios relative to the state average. Like California, the tendency is toward convergence and no area is below the state average at a statistically significant level. A similar three-year trend in admission rates for a representative rural area in southern Iowa is illustrated in Table 2c. Among the areas and between the states, there is remarkable consistency in the three and four year patterns.

Second, changes have also occurred in the mix of clinical categories as the share of admissions to local hospitals decreases. Typically, the small rural hospitals retain a high percentage of local residents' admissions for common medical cases - such as pneumonia, heart attacks, and strokes - the diseases of the elderly, mainly Medicare patients. But local residents appear to be going to other hospitals for much routine surgery, all specialized surgery, chemotherapy and many diagnostic procedures. Table 1 a, b, and c presents summary data showing this trend in four hospitals in Northeastern California, four in Washington, and for a 54-bed hospital in Leon, Iowa.

How much of the change in market share and occupancy rates for rural hospitals is technology driven? Table 1 reveals that local hospitals have relatively few or no admissions for procedures likely to be performed by a specialist or that require capital- and technology-intensive investment as in chemotherapy.

If the greater part of the hospital's total admission volume is composed of patients who suffer from the chronic diseases of old age - with relatively low DRG cost weights - there are implications as well for the mix of payors. Outside of obstetrics, these data suggest that small rural hospitals may be disproportionately dependent on Medicare for most of their revenues. This inference is further strengthened by the observation that these hospitals' share of per capita dollars is substantially smaller than their share of admission volume, and declining more rapidly (see Table 2 a, b, and c).

What are some other common characteristics of these rural hospitals? With a few exceptions, they are quite small. Of the 14 rural communities and hospitals profiled in this report, the average is 40 beds. Few are in genuinely remote, isolated areas. Rather, it appears that the proximity of somewhat larger hospitals, within 25 or often fewer miles, increases the probability that the small hospital with less diverse resources and staff will lose market share. While in some cases the principal beneficiary of a small hospital's decline is a large regional medical center, in others the beneficiaries are only slightly larger but more comprehensive general hospitals. Among the market areas profiled in Northern California, Enloe Memorial (201 beds, 83% occupancy) and Chico Community Hospital (135 beds, 53% occupancy) in Chico are major recipients of patients from Gridley, Paradise, Red Bluff, and Willows. In Washington, Samaritan Hospital in Moses Lake has been attracting patients that in the past might have been hospitalized in Othello.

All the hospitals in this preliminary study which have declining admissions or a decreasing share of residents' expenditures for hospital care have an extremely concentrated primary market, usually centered on a small town within a sparsely populated region. Residents within a short radius of the hospital make up 75% to 96 % of the hospital's total admissions.

On the other hand, in all but four of the 13 geographic areas where we've looked at this pattern, the small rural hospitals accounted for less than 50% of the resident's care and 15% to 35% of the residents' dollars for most of the three or four years under review (see Table 2 a,b,c).

Finally, these preliminary data and other sources suggest the declining occupancy rates and shrinking market share that generally accompany financial problems did not just suddenly appear with introduction of the Prospective Payment System. (Whether the DRG

reimbursement mechanism for Medicare has accelerated these trends is another question.) These trends are in evidence in California in 1983, appear to be well advanced in Washington and Iowa by 1985. Data reported in the American Hospital Association's annual Guide to the Health Care Field show generally reduced admissions and declining occupancy rates for many small hospitals, regardless of their location. Among the hospitals profiled in this preliminary study, occupancy averaged 31% during the periods under review. Several hospitals have "down-sized," reducing their licensed bed capacity, and a number are associated with nursing homes whose bed capacity is considerably larger than that of the acute care facility.

The variations in rates of service revealed by small area analysis are not all attributable to physician practice style differences. Levels of illness may vary among populations. Indeed, some variation is inevitable, and may reflect genuine differences in illness levels or other patient characteristics, as well as differences in the organization and availability of primary care or other resources in the health care system.

However, we have observed that the per capita admission rates for some conditions and procedures typically display high variation while others vary little from one hospital market area to another. The pattern that emerges suggests the role of uncertainty about outcomes of medical decisions is always present, no matter what other factors are influencing rates in a particular area.

High variation - or discretionary - causes of admission - coronary artery bypass surgery, adult gastroenteritis, adult pneumonia - tend to be characterized by greater controversy regarding the efficacy of or appropriate site for a particular treatment or by inconsistent or unclear diagnostic indicators. Low variation - or non-discretionary causes of admission - inguinal and femoral hernia repair, appendectomy, acute myocardial infarction - tend to be those for which the condition is rather clearly defined as to its presence, and where there is strong professional consensus concerning the choice and value of a particular treatment.

Typically, rural areas have higher per capita admission rates for treatment of discretionary medical conditions and surgical procedures than is true for the state as a whole. The precise reasons for this pattern will require additional information. For example, Graph 5 shows that admission rates for Hernia Repair, a low-variation procedure, show no statistically significant difference from the California state average among the composite rural area, and other low variation or non-discretionary admission categories also differ relatively little, while those among the higher variation or discretionary categories range from Back and Neck surgery at nearly twice the California average to heart failure at 15% below average.

Tentative Conclusions and their Implications for Policy

The state-specific tables on individual hospitals and the age and sex-adjusted rates of admission for the residents in the communities they serve show that a majority have admission rates at or in excess of their own state averages. Thus there is little evidence from these preliminary studies of systematic abridgement of access to hospital services from the perspective of rural residents because of the financial problems of a few rural hospitals.

From the perspective of the hospitals however, market share of total admissions does not translate to an equivalent portion of the total dollars spent by residents of their areas on hospital care. The concentration of admissions among medical conditions associated with chronic illness has strong implications for revenues and suggests that these hospitals have less flexibility for cost-shifting among payors. This concentration of clinical admission types also has implications for the hospital's ability to attract and retain physicians.

Area size is especially critical in population-based studies which seek to elucidate recommendations for public policy. Although attention here has focussed on rural health care patterns, the unit area size is particularly important in metropolitan areas where both the payor mix - Medicare, Medicaid, private insurance, worker's compensation, HMOs, even the number of uninsured - and the organization and capacity of non-hospital health services may strongly influence the rates of hospital utilization.

Data from CRG's analyses of hospital utilization in the District of Columbia, New York and California suggest that patients living in low income areas are more likely to be admitted to hospitals than those living in high income areas but are less likely to have elective surgery. Extremely low rates for a low variation surgical procedure such as inguinal and femoral hernia repair or appendectomy may signal problems with access which improved public sector resource planning, consumer awareness, and physician education can address. The key element for understanding the interplay of volume, cost, and quality of care is clinically relevant information that is specific to the geographic areas where physicians and

surgeons practice and the patients they treat reside. If unsatisfactory circumstances are to be modified, the planners and practitioners who are making and implementing the decisions must be able to see where the problems arise and how their actions contribute to the existing situations and to their solutions. Especially where access to health care is at issue, knowledge of local circumstances is vital if policymakers are to mobilize resources appropriately.

Finally, small area analysis is valuable for its quantification of utilization patterns, enhancing the utility of the information to policymakers as well as clinical practitioners. Quantification is necessary as a foundation for action aimed at changing either circumstances or behavior that is deemed inappropriate, whether through under- or overservice.

The detailed information on patterns of care for defined populations that emerges from small area analysis can help identify the characteristics of networks that appear to function optimally as well as those which present problems. Indeed, clinically relevant, area-specific information is the key to developing models for delivering efficient, high quality health care that meets local needs, just as it identifies and quantifies the problems which must be addressed.

Graph 1 Washington State

Hospital Market Area		Total Study Discharges		
Toppenish		1968		
Hosp Id	Hospital Name	Discharges	% of HHA	% of Hosp
199	Prov Central Mem	591	30.3	69.6
102	St Elizabeth	485	24.9	7.8
58	Yakima	435	22.3	6.6
87	Central Meriel	149	7.6	10.0
198	Sunnyside Community	70	3.6	5.7

Zip Code	Discharges	ST	City Name	Other Place Name
98948	945	WA	TOPPENISH	TOPPENISH
98953	359	WA	ZILLAN	ZILLAN
98932	250	WA	GRANGER	CREWPORT
				GRANGER
98952	177	WA	WHITE SWAN	WHITE SWAN
98933	110	WA	HARRAH	HARRAH
98921	67	WA	BUENA	PO BOX
98920	40	WA	BROWNSTOWN	PO BOX

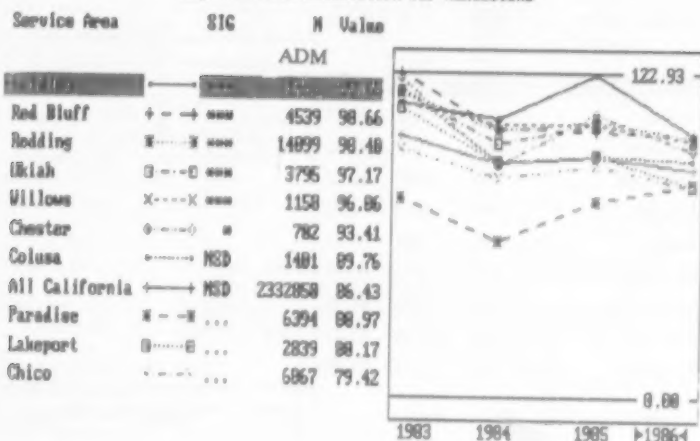
Graph 2 Washington State

Standard Hospital Specific Database for 1987
All Admissions in Toppenish

	Admissions	Patient Days	Dollars (\$000s)	Length of Stay	\$ (\$000s) Per Adm.
Data Totals	1948	11119	8536	5.7	4.4
Prov Central Mem	38.3%	24.7%	24.9%	4.7	3.6
St Elizabeth	24.9%	28.5%	38.5%	6.5	5.4
Yakima	22.3%	21.4%	16.6%	5.5	3.2
Central Meriel	7.7%	6.4%	6.3%	4.8	3.6
Sunnyside Communi	3.6%	2.6%	3.1%	4.1	3.8
New Valley Out	2.8%	2.5%	2.1%	5.8	3.2
Childrens	1.8%	2.8%	4.5%	8.6	18.6
University	1.1%	1.7%	1.8%	8.5	7.8
Swedish	0.6%	0.4%	0.5%	3.9	4.8
Virginia Mason	0.5%	0.3%	0.3%	3.2	3.8
ALL OTHERS	4.3%	8.7%	9.5%	11.6	9.6
Total or Avg	188.8%	188.8%	188.8%		

California

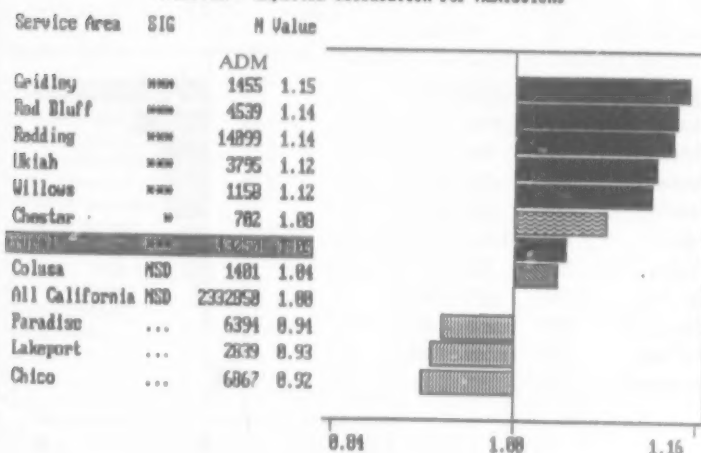
Graph 3 All Admissions - Standard Utilization - 1983 to 1986
Adjusted Rate Calculation For Admissions



Graph 3 a

California

All Admissions - Standard Utilization - 1986
Observed / Expected Calculation For Admissions

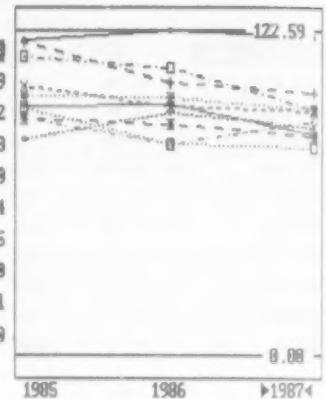


Washington State

Graph 4 All Admissions - Standard Utilization - 1985 to 1987
Adjusted Rate Calculation For Admissions

Service Area SIC N Value

ADM			
Metalline Falls	---	244	122.59
Morton	+	1045	90.29
Tonasket	+	861	92.62
Toppenish	+	1948	92.18
Othello	X	1093	91.70
Chelan	+	824	87.74
Colville	+	1579	85.65
Moses Lake	+	2896	82.98
All Wash	+	374196	82.21
Davenport	+	1023	70.28



Washington State

Graph 4 a All Admissions - Standard Utilization - 1987
Observed / Expected Calculation For Admissions

Service Area SIC N Value

ADM			
Metalline Falls	---	244	1.46
Morton	---	1045	1.20
Tonasket	---	861	1.13
Toppenish	---	1948	1.12
Othello	---	1093	1.12
rural	---	18712	1.08
Chelan	NSD	824	1.07
Colville	NSD	1579	1.04
Moses Lake	NSD	2896	1.01
All Wash	NSD	374196	1.00
Davenport	NSD	1023	0.95

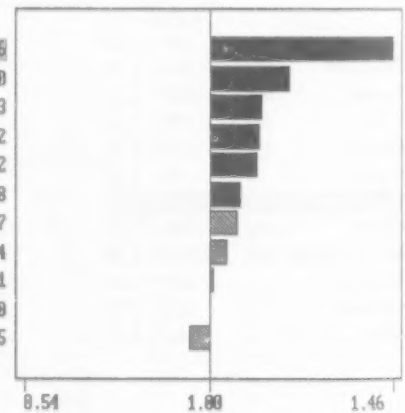


Table 1 a

1986 Market Share of Admissions by Clinical Category
Four Rural Hospitals, Northeastern California

Hospital	<u>Glenn Gen.</u>	<u>Biggs-Gr</u>	<u>Seneca</u>	<u>Feather Riv</u>
all admissions	48.7	42.4	49.3	41.9
adult pneumonia	95.4	75.9	89.6	63.5
ad bronchitis/asthm	75.0	31.8	68.4	52.7
acute myocardia inf	73.1	68.3	75.0	62.8
coronary art bypass	0	0	0	0
cholecystectomy	52	56.7	100	52.9
major joint ops	0	18.2	0	37.7
back and neck ops	22	4.5	0	15.9
prostatectomy	41.7	24.0	0	57.4
chemotherapy	0	0	0	0
hysterectomy	13.0	18.2	36.4	47.6

Table 1 b

1987 Market Share of Admissions by Clinical Category
Five Rural Hospitals, Washington

Hospital	<u>Providence</u>	<u>Morton Gen</u>	<u>Mt. Carmel</u>	<u>Mr. Linton</u>	<u>N. Valley</u>
	<u>Central Mem</u>				
all admissions	30.3	30.1	53.2	51.2	53.4
adult pneumonia	57.1	68.6	84.9	81.8	75.0
ad bronchitis/asthm	40.9	57.1	55.4	80.0	93.7
acute myocard inf	28.3	30.3	90.6	50.0	92.9
coronary art bypass	0	0	0	0	0
cholecystectomy	37.9	55.5	78.1	66.7	80.0
major joint ops	3.3	0	0	0	0
back and neck ops	0	0	0	0	0
prostatectomy	16.7	0	0	0	18.2
chemotherapy	0	0	0	no adm	0
hysterectomy	9.8	38.5	57.1	40.0	54.2

Table 1 c

1987 Market Share of Admissions by Clinical Category
Decatur County Hospital, Leon, IA

all admissions	61.4
Adult pneumonia	93.5
ad bronchitis/asthm	84.6
acute myocard inf	65.1
coronary art bypass	0
cholecystectomy	56.4
major joint ops	30.6
back and neck ops	0
prostatectomy	7.1
chemotherapy	0
hysterectomy	62.5

Table 2 a Northern California: Trends in Admission Rates, Hospital Market Share, and Occupancy Rates in Selected Rural Communities 1983-1986

Chester HMA	Seneca Hospital		Beds 26 (1984)	14 (1986)
	1983	1984	1985	1986
admissions/1,000	121.01	87.54	106.78	93.41
hospital share of adm	53.8	51.3	51.6	49.3
hospital share of \$	36.4	33.9	31.5	30.0
hospital occupancy				28%
% hospital represented by local residents				85.9
Gridley HMA	Biggs-Gridley Hosp.		Beds 55	
	1983	1984	1985	1986
admissions/1,000	111.31	104.88	121.90	99.65
hospital share of adm	51.4%	45.3	48.7	42.4
hospital share of \$	39.4%	30.4	34.2	33.8
hospital occupancy	34.5%			
% hospital represented by local residents				70.7
Paradise HMA	Feather River Hosp.		Beds 125 (1984)	120 (1986)
	1983	1984	1985	1986
admissions/1,000	75.06	58.90	73.53	80.97
hospital share of adm	65.6	59.5	46.7	41.9
hospital share of \$	54.8	48.7	38.2	34.0
hospital occupancy				44.9%
% hospital represented by local residents				75.4
Willows HMA	Glenn General Hosp		Beds 62	
	1983	1984	1985	1986
admissions/1,000	111.31	103.13	103.19	96.86
hospital share of adm	45.5	50.5	49.4	48.7
hospital share of \$	30.2	34.1	33.2	32.1
hospital occupancy		40.3		
% hospital represented by local residents				73.9

Table 2 b Washington: Trends in Admission Rates, Hospital Market Share, Occupancy Rates in Selected Rural Communities 1985-1987

Colville HMA	Mount Carmel Hospital		Beds 48
	1985	1986	1987
admissions/1,000	80.92	90.00	85.65
hospital share of adm	50.9	54.4	53.2
hospital share of \$	37.0	38.3	35.9
hospital occupancy			27
% hospital represented by local residents			87
Davenport HMA	Lincoln Hospital		Beds 24
	1985	1986	1987
admissions/1,000	92.82	79.06	78.20
hospital share of adm	39.7	38.5	34.0
hospital share of \$	21.4	19.2	15.8
hospital occupancy	37		37
% hospital represented by local residents			92.8
Minnehaha Falls HMA	Missoula-Lewiston Hosp		Beds 38
	1985	1986	1987
admissions/1,000	118.62	122.36	119.40
hospital share of adm	63.4	57.1	51.2
hospital share of \$	40.1	33.2	28.7
hospital occupancy	31		
% hospital represented by local residents			90.2

(Table 2 b cont.)

Tonasket HMA	North Valley Hosp	Beds 22	
	1985	1986	1987
admissions/1,000	97.11	96.77	92.62
hospital share of adm	51.4	53.3	53.4
hospital share of \$	38.5	40.7	33.2
hospital occupancy	35		25
% hospital represented by local residents			96.4
Toppenish HMA	Prov Central Mem	Beds 63	
	1985	1986	1987
admissions/1,000	112.44	107.89	92.18
hospital share of adm	41.8	40.4	30.3
hospital share of \$	33.7	33.8	24.9
hospital occupancy	41.3		28.6
represented by local residents			70
Chelan HMA	Lake Chelan Hosp	Beds 34	
	1985	1986	1987
admissions/1,000	89.04	79.26	87.74
hospital share of adm	45.6	40.9	45.9
hospital share of \$	36.5	29.8	28.3
hospital occupancy	28.6		
% hospital represented by local residents			69
Morton HMA	Morton General	Beds 20	
	1985	1986	1987
admissions/1,000	177.70	102.37	98.29
hospital share of adm	35.1	36.0	30.1
hospital share of \$	20.3	24.1	17.4
hospital occupancy			
% hospital represented by local residents			27.5
Moses Lake HMA	Sammaritan Hosp	Beds 50	
	1985	1986	1987
admissions/1,000	93.55	94.02	82.90
hospital share of adm	62.0	64.1	59.3
hospital share of \$	52.1	50.6	46.6
hospital occupancy	70		54
% hospital represented by local residents			74.5
Othello HMA	Othello Hospital	Beds 38	
	1985	1986	1987
admissions/1,000	180.80	93.33	91.70
hospital share of adm	39.2	38.5	39.2
hospital share of \$	25.4	24.7	23.2
hospital occupancy			38
% hospital represented by local residents			82.2

Table 2 c

Southern Irons: Trends in Admission Rates, Hospital Market Share, and Occupancy Rates in Lewis, Iowa 1985-1987

Lewis HMA	Encounter County Hosp		Beds 34
	1985	1986	1987
admissions/1,000	125.21	118.33	127.25
hospital share of adm	71.3	62.3	61.8
hospital occupancy	39		37
% hospital represented by local residents			78.2

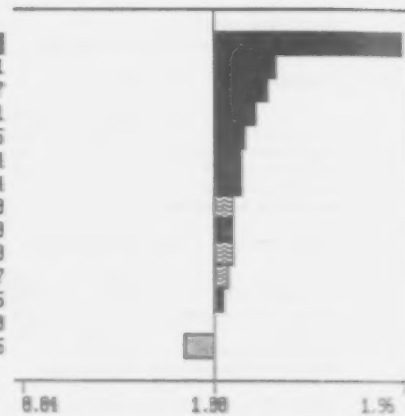
Graph 5

California

rural - Standard Utilization - 1986
Observed / Expected Calculation For Admissions

Case Mix SIG N Value

Case Mix	SIG	N	Value
Hysterectomy	####	1868	1.31
CoronaryBypass	####	422	1.27
AdultPneumonia	####	1165	1.21
Maj Joint Ops	####	579	1.15
Cholecystectomy	####	718	1.14
AdultBronchitis	####	924	1.14
Appendectomy	"	518	1.13
ADT Gastro-ent	####	1239	1.13
Prostatectomy	"	675	1.13
Acute M.I.	"	946	1.07
All Admissions	####	43258	1.05
Ing Fem Hernia MSD		289	1.00
Heart Failure ...		998	0.85



Chairman STARK. We must take a very brief recess.

[Recess.]

Chairman STARK. We can proceed at this time.

Jim Bernstein is next on the list. You may proceed in any manner you are comfortable.

STATEMENT OF JAMES D. BERNSTEIN, CHIEF, OFFICE OF HEALTH RESOURCES DEVELOPMENT, NORTH CAROLINA DEPARTMENT OF HUMAN RESOURCES, RALEIGH, NC

Mr. BERNSTEIN. Thank you, Mr. Chairman. My name is Jim Bernstein. I am chief of the Office of Health Resources Development in the State of North Carolina. I would like to take credit for those favorable rates on the screen, but I don't think I can do that.

Our office is responsible for developing rural primary care centers recruiting physicians, and assisting rural hospitals. Since 1973, we have developed 43 community-owned rural health centers, have recruited over 800 physicians to rural communities, and have devoted considerable resources to developing innovative systems of care for our rural areas.

I appreciate the opportunity to testify before you today. Rural hospitals are under utilized, under staffed, and under compensated. I believe all hospitals and physicians must be reimbursed equitably and adequately, regardless of their location. For the majority of our rural hospitals—those hospitals which are larger and well-maintained and which serve economically diverse rural areas—equity in Medicare reimbursement will help to assure their survival.

A higher rate of reimbursement, however, does not mean that hospital boards, medical staffs, and county leaders will be released from making responsible decisions.

Rather, higher reimbursement rates will permit them to focus on the changes that are needed: improving quality of care; exploring opportunities for diversification; and developing systems of care to meet the future needs of their communities.

My main concern here today lies with the minority of our rural hospitals—those small, aged hospitals typically located in poor, sparsely populated areas. Higher rates of reimbursement alone will not solve their problems.

I agree, you could triple the reimbursement rate for these hospitals and it probably would not make a difference. The problems of these hospitals go beyond reimbursement. They reside in the nature and plight of the communities they serve. These are the poorest areas of rural America, where unemployment and poverty are the highest, where schools and housing are the most inadequate, and where health status is the lowest.

The Federal Government's role in assisting hospitals in rural areas like these should be in encouraging communities to assess their needs and develop the appropriate services to meet those needs.

To accomplish this, Federal Government agencies will need to improve the interagency coordination of their own assistance programs, target their programs to the communities most in need, and provide incentives to the communities most in need to begin an assessment and rebuilding process.

Basically, the most isolated and/or poorest rural communities need a rational health care delivery plan for the 1990's, adequate reimbursement from Medicare, access to capital for renovation or new facilities, and a manpower policy that would provide adequate incentives to induce physicians to locate and remain in these areas.

A basic assumption to all of this is a process by which we can identify those communities where existing health care services are in jeopardy and whose populations are at risk for losing access to care. I am proposing a mechanism for designating such communities as "Special Hospital Need Areas."

I further propose that those areas so designated will receive priority for Federal and State assistance or, at the very least, parity with other designations for Federal assistance. The designation mechanism should be flexible and should be developed with the individual States so that differences in the rural characteristics would be considered.

For example, the definition and needs of rural populations in agriculturally-based North Carolina are vastly different from the frontier populations of Nevada. That is why just the distance factor is not sufficient to make a determination.

The role of State governments in special hospital need areas: States will, with the Federal Government, designate special hospital need areas; assure coordination of Federal and State assistance, approve the community plans for restructuring of local health care systems.

Specific ideas to consider are:

Develop a new part A reimbursement program for hospitals that wish to close their acute care beds to develop more innovative programs to care for the community's needs.

The Rural Health Clinic Act—Public Law 95-210—in part A is a helpful reimbursement program yet it requires many changes for its fullest potential to be realized; mostly in the area of reducing burdensome rules and regulations. It might be preferable to do a thorough examination of Public Law 95-210 than to create a new category.

Section 4043—incentive payments for physicians in underserved areas—is another potentially useful concept that requires increased reimbursement and improved targeting.

The new Rural Hospital Transition Grants Program funding could be increased with priority on special hospital need areas.

The NHSC State Loan Repayment Program is an excellent program that requires increased funding and targeting at the special hospital need areas.

An option could be to fund new community health center 330/329 starts in special hospital need areas.

Priority could be made in FmHA loans for developing facility components of approved systems in special hospital need areas.

We need to reexamine Federal and State laws and regulations of health programs for their appropriateness to small rural facilities.

States need to coordinate their resources, such as technical assistance, personnel recruitment, loan forgiveness, and capital assistance programs with Federal resources to impact the special hospital need areas.

In conclusion, I appreciate this opportunity to appear before you today and to share some of my thoughts on rural hospitals and health care. If I had to leave you with one message, it would be that for the high risk rural areas of the country, whether they be small isolated frontier communities or poor Appalachian communities, the solution to the rural hospital problem is not just more reimbursement in Medicare part A. A comprehensive, coordinated action directed at maintaining and improving the total delivery program is required.

Chairman STARK. Thank you very much.

[The statement of James D. Bernstein follows:]

TESTIMONY OF JAMES D. BERNSTEIN
BEFORE THE SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
MAY 15, 1989

My name is James Bernstein and I am Chief of the North Carolina Office of Health Resources Development (OHRD). Our office is responsible for developing rural primary care centers, recruiting physicians, and assisting rural hospitals. Since 1973, we have developed 48 community-owned rural health centers, have recruited over 800 physicians to rural communities, and have devoted considerable resources to developing innovative systems of care for our rural areas. I also serve as Co-Director of the NC Rural Health Research Program at the Health Services Research Center at UNC, Chapel Hill, and as Chairman of the Advisory Panel to the Office of Technology Assessment's study on rural health care. I appreciate the opportunity to testify before this Committee today.

BACKGROUND

Very briefly, rural hospitals are:

- Underutilized. Nationally, the average occupancy rate of rural hospitals is 40%. This means that, on any day, more than half the beds in these hospitals are empty. While there has been a general trend of declining admissions for most hospitals -- urban and rural, large and small -- ProPAC data has shown the rate of decrease in admissions to rural hospitals was three times larger than the rate for urban hospitals for the years 1984 to 1987. Anecdotal data for 1988 and 1989 indicate that the decline in admissions and the disparity between urban and rural admissions has continued.
- Understaffed. The financially precarious position of most of our rural hospitals compounds the difficulties in recruiting physicians to rural areas. Physician recruitment in North Carolina is a collaborative effort of OHRD, the AHEC program, the family medicine residency programs, and our 330/329 Community Health Centers. While I am proud of our progress in recruiting physicians over the past 16 years, the future does not look good. Our rural counties have 45% fewer primary care physicians per 1000 citizens than our urban areas. Even more significant is that more than half of our rural counties have fewer primary care physicians than they did in 1980. The recruitment of physicians to rural areas is difficult; but the recruitment of physicians to rural counties where the hospitals are financially distressed, employment for spouses is limited, and poverty is high is even more difficult. Rural areas need to be competitive with urban areas in clinical excellence, professional growth opportunities, salary and benefits in order to recruit and retain qualified health professionals.
- Undercompensated. Under the prospective payment system, urban hospitals are paid, on average, 40% more than rural hospitals. The lower compensation rate and the declining inpatient volume has meant that many rural hospitals have suffered. Access to care, particularly for the elderly, becomes a critical concern. Though there is nothing this Committee can do about the trends affecting the inpatient use of rural hospitals, how those services are paid for can be addressed. The most widespread adjustments in the DRGs for rural areas helps, but the increases are small compared to the losses sustained.

EQUITY IN MEDICARE REIMBURSEMENT

All hospitals and physicians must be reimbursed equitably and adequately regardless of their location. For the majority of our rural hospitals — those hospitals which are larger and well-maintained and which serve economically diverse rural areas — equity in Medicare reimbursement will help to assure their survival. A higher rate of reimbursement, however, does not mean that hospital boards, medical staffs, and county leaders will be released from making responsible decisions. Rather, higher reimbursement rates will permit them to focus on the changes that are needed: improving quality of care; exploring opportunities for diversification; and developing systems of care to meet the future needs of their communities.

My main concern here today lies with the minority of our rural hospitals — those small, aged hospitals typically located in poor, sparsely populated areas. Higher rates of reimbursement alone will not solve their problems. The problems of these hospitals go beyond reimbursement — they reside in the nature and plight of the communities they serve. These are the poorest areas of rural America, where unemployment and poverty are the highest, where schools and housing are the most inadequate, and where health status is the lowest. An example is Warren County, North Carolina (population 8347) located one hour north of our thriving "Research Triangle."

A RURAL HOSPITAL CASE STUDY

Warren County is 100% rural, largely agricultural, and has a median family income of \$12,008, which is 22% lower than the state average of \$15,326. There are more children living in poverty in Warren County than any other county in the state — 71% versus the state average of 22%. The infant mortality rate is 34% higher than the state as a whole.

In 1985, the Warren County Commissioners requested our advice about their failing 37-bed hospital. The hospital was seriously in debt, the census was low, the roof needed immediate replacement, the suppliers were refusing to provide credit, and the medical staff was down to one full-time equivalent physician. 63% of the hospital's revenues were derived from Medicare. After several months of meetings, it was decided the appropriate action was to close the hospital. As one would expect, it was not a popular decision. Public meetings were held — the courthouse was standing room only. No one spoke in favor of the decision. The community was afraid of losing not only what was left of the medical staff and their emergency room, but they also feared the loss of the second largest employer in the county.

After a thorough analysis of the situation, we recommended an alternative use for the hospital that would help meet the community's needs for health care. Specifically, the recommendation was to establish a coordinated community health/public health center. Unfortunately, to make this type of transition, the community needed to raise capital and to obtain higher and more equitable reimbursement from Medicaid and Medicare. The latter was not possible but the needed capital was raised in 1988 through the passage of a bond issue to renovate the hospital building into a primary care/public health center. However, the money was not raised without incurring other social costs — the competing priorities that lost out were schools, jails, and other badly needed services. But, the community was fortunate that through a special coordinated effort of our state agency and the Bureau of Health Care Delivery and Assistance, they were able to hire three additional physicians (the hospital, until that time, had two part-time physicians).

I have used the Warren County hospital as an example of the "minority of rural hospitals" mentioned above. Warren County is the poorest county in the state, is sparsely populated, has a growing elderly population, and an eroding tax base. Over the last five years, the community struggled, quite literally, to save their only hospital — an old, decrepit, structurally-outdated building with a mountain

of debts. Their struggle will continue -- it will be at least a year before their new health center will be complete.

Other rural hospitals struggling to survive have taken less drastic measures than Warren County. We have worked with hospitals which decided to maintain some of their hospital beds but converted some of the unused beds to skilled or intermediate nursing care use. The health care delivery plans for these hospitals are focused on developing a comprehensive range of inpatient and outpatient services for the elderly in their communities. The elderly are the least able to travel outside their own communities for services.

Though the mix of services may vary, community efforts to improve or restructure health care systems have common elements: the assessment of community needs and the development of services that respond to those needs. I am convinced that the federal government, in collaboration with state governments, needs to be encouraging this type of process.

THE ROLE OF THE FEDERAL GOVERNMENT: A CASE FOR DESIGNATING "SPECIAL HOSPITAL NEED AREAS"

The federal government's role in assisting hospitals in rural areas like Warren County should be in encouraging communities to assess their needs and develop the appropriate services to meet those needs. To accomplish this, federal government agencies will need to improve the inter-agency coordination of their own assistance programs, target their programs to the communities most in need (such as Warren County), and provide incentives to the communities most in need to begin an assessment and rebuilding process.

Basically, the most isolated and/or poorest rural communities need:

- a rational health care delivery plan for the 1990s.
- adequate reimbursement from Medicare
- access to capital for renovation or new facilities
- a manpower policy that would provide adequate incentives to induce physicians to locate and remain in these areas.

A basic assumption to all of this is a process by which we can identify those communities where existing health care services are in jeopardy and whose populations are at risk for losing access to care. I am proposing a mechanism for designating such communities as "Special Hospital Need Areas." I further propose that those areas so designated will receive priority for federal and state assistance or, at the very least, parity with other designations for federal assistance. The designation mechanism should be flexible and should be developed with the individual states so that differences in the rural characteristics would be considered. For example, the definition and needs of rural populations in agriculturally-based North Carolina are vastly different from the frontier populations of Nevada.

THE ROLE OF STATE GOVERNMENTS IN "SPECIAL HOSPITAL NEED AREAS"

States will:

- with the federal government, designate "Special Hospital Need Areas"
- assure coordination of federal and state assistance
- approve the community plans for restructuring of local health care systems.

SUGGESTIONS FOR CHANGES IN EXISTING GOVERNMENT PROGRAMS

Specific suggestions are:

Medicare, Part A:

- Develop a new Part A reimbursement program for hospitals that wish to close their acute care beds to develop more innovative programs to care for the community's needs.
- Provide an adjustment for the "Special Hospital Need Areas"

Medicare, Part B:

- The Rural Health Clinic Act (PL 95-210) is a helpful reimbursement program yet it requires many changes for it's fullest potential to be realized, mostly in the area of reducing burdensome rules and regulations
- Section 4043 (Incentive Payments for Physicians in Underserved Areas) is another potentially useful concept that requires increased reimbursement and improved targeting.

Rural Hospital Transition Grants:

- Increase funding with priority on "Special Hospital Need Areas"

NHSC State Loan Repayment Program:

- An excellent program that requires increased funding

Community Health Centers 329/330:

- New money for new starts in "Special Hospital Need Areas"

FMHA:

- Priority for developing facility components of approved systems in "Special Hospital Need Areas"

Federal and State Regulations:

- Re-examine federal laws and regulations of programs for their appropriateness to small rural facilities.

Other Resources Available Through the States:

- Coordination with state resources, such as personnel recruitment programs, loan forgiveness programs, and technical assistance.

CONCLUSION

I appreciate the opportunity to appear before you today and to share some of my thoughts on rural hospitals and health care. If I had to leave you with one message, it would be that for the high risk rural areas of the country, whether they be small isolated frontier communities or poor Appalachian communities, the solution to the rural hospital problem is not just more reimbursement in Medicare Part A. A comprehensive, coordinated action directed at maintaining and improving the total delivery program is required.

STATEMENT OF STEVEN ROSENBERG, PRESIDENT, ROSENBERG ASSOCIATES (CONSULTANT, NATIONAL RURAL HEALTH ASSOCIATION), BOLINAS, CA

Chairman STARK. Mr. Rosenberg.

Mr. ROSENBERG. Mr. Chairman, without objection, I would like to enter my written comments into the record.

Chairman STARK. Without objection.

Mr. ROSENBERG. I am on contract to the National Rural Health Association. We have recently been doing a study in your honor State examining the role of Medicare participation on survival in small, isolated rural facilities.

I would like to report on that and put it in context of various policy actions and make some recommendations to the committee.

As you know, there are several bills that have been presented to the House that attack the problem of these isolated, small rural facilities in different ways. They range from H.R. 950, the proposal to create a new benefit to H.R. 762 and H.R. 1583 to create financing equity to bumping up the rural program, to H.R. 3237 to allow States to create waivers appropriate to their specific needs.

In California, we have been working on a program to develop such a waiver under the provisions of 2148. We have been creating a building block approach to the new rural hospital. I want to stress my perspective that however this benefit is structured, it is important that it be a part A benefit to allow these facilities to have swing beds and skilled nursing beds which is a vital part of the isolated rural facility.

In California, we have looked at the possibility of developing standards of participation that were appropriate to small rural facilities which by and large do not do surgery, do not need lab call and x ray technicians 24 hours a day and created a holding pattern. Our research indicates it would be budget neutral to create new standards of participation, and these facilities would be able to survive, given their current patient mix.

In fact, as I think you said, many of these patients are already voting with their feet. In California, we are using a cutoff of 96 hours as length of stay, and we find fewer than 20 percent of patients stay longer than 96 hours currently. With that in mind, we have developed a building block approach to determine what services are appropriate to them.

There would be core services, emergency care, basic lab and x ray and holding beds and the option to add on OB and inpatient surgery as the community deemed fit.

We particularly like this building block approach because it allows each local community to determine a bottom up perspective on what needs they have within their community. We have widespread political support in the State, including the nursing association, the hospital and the medical association, and the association of district hospitals.

To some extent, I want to say it has been important that these initiatives have been supported solely with State funds, not from Medicare or Federal funds, but from taxpayers in California who recognize the crucial need for survival of rural hospitals.

The research base we are using in California is somewhat inadequate to enable you to properly structure a new Medicare part A benefit. I think for that reason, the California activity is a cautious, prudent approach.

If the chairman thought it was prudent to develop a benefit this year, I would like to encourage you to take a careful look at expanding the Rural Health Clinics Act, with particular attention to some of its provisions which have responded to some of the confusions around the closed medical facilities.

This program already has defined conditions of participation. They would not need to be rewritten, except relative to the holding beds. Already there is substantial interest among facilities in becoming involved with the program.

The Rural Health Clinics Program already has a part A benefit structure to it. It has a visiting nurses structure which allows it to become a hub of comprehensive care. It requires the use of mid-level practitioners. Additionally, in California, all of our target hospitals are eligible for participation and two out of three would have little problem to increase bed size to six and maximum stay to 96 hours.

Finally, the Rural Health Clinics Program is not tied to demonstration, but rather provides a continuous benefit. There are two additional sections I would recommend adding. One would be that currently you have Medicare and Medicaid tied under the Rural Health Clinics Program for all providers. If you develop the new primary care hospital concept, it would be appropriate to allow some State input to determine which facilities should be channeled into that; and second, I think there will be some need for capital for renovations and community development in order to achieve these. I would encourage the chairman to do that in any bill developed.

Finally, I would like to express my appreciation to the chairman and the committee for their efforts to limit the ability of physicians to profit from their referrals. I am most appreciative of those efforts, both intellectually and as a consumer of health care. I would also like to express my appreciation to the chairman and the committee in exempting certain rural communities from some of those constraints.

As you are no doubt aware, in many rural communities, it is desirable for providers to consolidate, merge and develop joint ventures as a way of trying to maximize efficiency where volume is low. I would also like to go on record with my concern that the proposed safe harbor rules (42 CFR 1001), do not seem to show the chairman's understanding concerning the specific delivery issues in low-volume locations and the appropriateness of provider interrelationships in those locations.

I personally know of several isolated rural communities in which physicians are planning to leave the area if their small local hospitals will not acquire their practices.

This is not competition, it is survival. In two of these cases, these are the only docs in town; and in both cases, the acquisition has been put on hold because of the proposed safe harbor regulations.

I would therefore urge the members of the committee to use their influence with the inspector general to clarify this aspect of

42 CFR 1001 and provide a specific safe harbor for the merger of physicians and hospitals in isolated rural communities without the merger forcing the retirement of the physicians.

Once again, I would like to thank the committee for this opportunity to testify.

[The statement of Steven Rosenberg follows:]

rosenberg associates box 16 elm road, bolinas, ca. 94724 (415) 868-0180

*Testimony of Steven Rosenberg before the Health Subcommittee
of the House Ways and Means Committee, May 15, 1989*

Good afternoon, Mr. Chairman, and members of the committee. My name is Steven Rosenberg, and I am president of Rosenberg Associates, a California-based health care consulting firm that is serving as consultants to the National Rural Health Association on the development of alternative models of rural health care delivery and working as a sub-contractor to the association on a contract with the State of California to explore the feasibility of alternative models of rural care that may be appropriate in a state as diverse as California. I would like to express my personal appreciation to this committee for its foresight in holding these hearings. I have spent my entire professional career working in isolated rural communities seeking to assure access to health services. While I am gravely concerned about changing delivery patterns in rural America, I believe that this is a most appropriate time in which to explore the development of alternative models of rural delivery.

Prior to any discussion of alternative model development, it is essential that we move rapidly toward a single national rate that does not discriminate against rural hospitals. It is only with a level playing field that rural hospitals can compete successfully. In the interim till a single national rate is established, access must be preserved in rural hospitals that are heavily dependent on Medicare. Hospitals with 50 percent or more of their business coming from Medicare should be protected during the transition to a single national rate by payments at cost. It should be noted, however, that equity is unlikely to resolve the problems of small, isolated rural facilities whose volume is insufficient to enable them to cover their fixed costs, and something must be done to protect these essential facilities in the long-run, as well.

I recently prepared a policy paper for the National Rural Health Association reviewing the economic and social implications of the potential closure of rural facilities. The paper reviews a variety of policy options that have been discussed as strategies to preserve essential access hospitals. I would like to briefly summarize the conclusions of that paper, place those conclusions in the context of various legislative efforts currently underway, and then discuss the study we are currently performing in the chairman's home state of California.

After the issue of payment equity has been addressed, there are four policy options, not all of which are mutually exclusive, that could be used to create alternative rural health delivery systems for essential access facilities. The first option would be to create a new Medicare benefit similar to the Medical Assistance Facility currently being researched in Montana. Congressman Roybal has proposed such a benefit called the Medical Care Access Facility in H.R. 950, and others, including members of this committee, are considering similar legislation. While such a benefit might in fact represent a solution to the problems of remote rural facilities, there is no substantive data that would indicate which types of communities would be best served by such facilities. There are also some substantial concerns about what conditions of participation would be appropriate for such a provider and how to best reimburse such providers. Additionally, while the MAF model may be appropriate to a state such as Montana, there are serious questions as to whether the model would be appropriate in other states.

The second policy option would be to enhance the Rural Hospital Transition Grants Program authorized by the Congress in 1987 and funded last year. This program allows rural hospitals to explore the different ways in which they can best reconfigure or restructure in order to meet the specific needs of their own communities. Additionally, the requirement that states process applications assures their input in the selection of facilities for which transition is appropriate.

The third policy option would be to create a targeted category of rural providers whose survival is essential to access to care, as has been suggested in H.R. 762 and H.R. 1583, and to pay these providers in such a way as to assure their continued operation. The development of criteria to target those hospitals may, however, be problematic, but not impossible.

The fourth policy option would be to require the Health Care Financing Administration to grant waivers to several states to facilitate the development of different kinds of alternative rural facilities. This option would have many of the advantages of the first policy option discussed. It would create of a new national benefit for "medical assistance-type facilities" while still allowing time to test what types of models are most appropriate in different communities. Several states have already begun efforts in this direction. Shortly, I will discuss the specific efforts that are currently underway in California to develop a waiver application, as well as some personal recommendations as to how the committee might integrate the best features of all of these policy options.

Whenever policy option or combination of options are selected, it is my belief that it is essential that any new benefit or waiver either be structured as a Part A benefit or that the Part B rules be substantially revised to enable Part B providers to offer long-term care services. For most small rural hospitals, the provision of skilled nursing care either through a distinct part Skilled Nursing Facilities (SNF) or a swing bed program, is a key component of their care program. For facilities to maintain participation in the distinct part and/or swing bed programs, an alternative model must be structured to

allow and encourage the provision of these long-term care services. This is especially true given the high proportion of elderly in rural communities.

While much of the focus of the discussion on alternative models of rural hospitals has centered on reimbursement, I would like to turn the committee's attention to another essential aspect of the alternative model—the conditions of participation. Many analysts have concluded that one of the barriers to survival for small rural facilities is the requirement that they meet the same conditions of participation as are required of tertiary teaching hospitals. Several states are in the process of reviewing their own licensure requirements for rural hospitals in an effort to create regulatory relief, but most all efforts at relief have been stilled by the existing Medicare conditions of participation for hospitals which are often inappropriate for small facilities with limited medical staffs.

In California, Rosenberg Associates and the National Rural Health Association have been working to define what conditions of participation would be appropriate to small rural hospitals and to test the impact of such regulatory relief on the financial viability of rural facilities. Our work has been authorized by Assembly Bill 2149, which in addition to mandating a review of hospitals, also required the development of pilot projects defining alternative hospitals that could lead to the development of a waiver application.

In analyzing the data from California hospitals, we found that there was substantial local and regional differences both in the types of service currently being provided and in the patients seen in rural hospitals throughout the state. Because California has such a diverse rural economy, it was felt that no single alternative model would appropriate throughout the state. Additionally, it was assumed that for an alternative model of care to be effective, local input was essential and that a "top-down" approach to defining an alternative that did not take into account local needs and local resources would be less than successful.

Toward that end, we have developed a "building block" approach to model development in which each pilot project would be required to offer a set of core services: standby emergency care, primary care, holding or stabilization beds in which patients could stay up to 96 hours, basic laboratory and basic radiology services. Additionally, communities can choose to add on modules of services as may be appropriate to the specific needs of their communities. There are four add-on modules which can be selected: obstetrics, inpatient and outpatient surgery, expanded radiology and expanded inpatient care.

The way the project is designed, as a community chooses additional modules, the regulatory noise tightens so that the closer a community comes to offering the full range of services offered by a typical rural hospital, the closer the conditions of participation would be to those required of a regular hospital. With the assistance of a Technical Advisory Committee composed of representatives of the State Office of Health Planning and Development, the Department of Rural Health, the Licensing and Certification Department, the California Association of Hospitals and Health Systems, the Association of California District Hospitals, the California Medical Society, the California Nurses Association and several providers, Rosenberg Associates has defined conditions of participation for each of the components of the core, as well as each of the add-on modules.

Those proposed conditions offer the opportunity for substantial cost savings in areas such as staffing by allowing for multi-competency technicians, instead of separate lab and x-ray technicians, and in areas such as quality assurance and utilization review by developing procedures that are specifically appropriate for hospitals with small medical staffs. Currently, we are reviewing the financial implications of these relaxed regulations on the operation of these isolated facilities. Our initial review indicates that there are substantial cost savings with a limited loss of revenue, since the vast majority of patients at the three hospitals we are using in the pilot study already stay in the facilities fewer than 96 hours.

To some extent, then, our efforts can be seen as trying to retrofit regulations to what these isolated hospitals are already doing in their own efforts to survive. I would like to point out to the committee that all three of our pilot facilities are tax-supported and are nevertheless experiencing substantial losses despite their public subsidy. It is our belief that by encouraging a "bottoms-up" approach to planning that allows each community to define which add-ons they would select and thus the scope of services most appropriate to their communities, the likelihood of communities providing additional tax support when necessary is increased.

I would like to emphasize that ground-breaking aspects of our efforts in California have been solely supported through state funds. It is my belief that the high level of commitment shown by the state in the development of alternative models is indicative of the strong level of interest growing throughout the country. While this state commitment to research and exploration is both useful and laudable, it is not a national program defining a national benefit. It is probably time to develop such a national program, similar to the swing bed program, in conjunction with private foundations.

Because the research base on which to structure such a national model is still evolving, if the members of the committee deem it appropriate to create a model now, rather than encourage more demonstration projects through a waiver process, I would like to recommend what I consider to be both a prudent and efficient course to model development. My recommendation would be that the committee take

advantage of a piece of existing legislation, Public Law 95-210, the Rural Health Clinics Act, by creating a new category of 95-210 provider (called a "primary care hospital" for lack of a better name) which would be certified to offer and be reimbursed for holding or stabilization beds that kept patients for up to 96 hours. There are several advantages of using an existing piece of legislation such as Public Law 95-210 as the mechanism through which to create a new model:

1. P.L. 95-210 is already targeted to rural areas that have a shortage of health resources. While many communities that qualify for participation in 95-210 do not have a hospital, most of those qualifying communities that do have hospitals have facilities that are in distress. One way in which a new 95-210 benefit could be targeted specifically to low-volume facilities would be to limit the number of beds that a facility certified under the benefit could have. An appropriate number of beds that could be certified under the benefit might be six or fewer.
2. P.L. 95-210 already has defined conditions of participation. It would only be necessary, therefore, to establish conditions of participation for the holding beds. The conditions of participation in 95-210 are flexible and would allow for the development of models that are most appropriate to the specific needs of particular rural communities.
3. The regulations implementing 95-210 have already created a category of "provider-based rural health clinics." While fewer than 15 providers were certified under that provision of the Act as of the beginning of this year, there has been a growing interest among rural hospitals in 95-210. There have also been some administrative problems with HCFA in implementing the provider-based benefit, and clarifying legislation would be most welcome.
4. Provider-based rural health clinics are an existing Part A benefit to which other essential community services such as skilled nursing or swing beds could be added without modifying the participation requirements for those services.
5. 95-210 already contains a provision that allows for the delivery of visiting nurse services in areas that have a shortage of home health agencies, thus allowing those providers located in remote and isolated areas to build a spectrum of care.
6. 95-210 already requires the use of mid-level practitioners as has most of the proposed legislation that explores the medical assistance facility concept.
7. In our California study, all three of our target hospitals are 95-210 eligible and two of the three would have little problem decreasing their bed size to six and their maximum length of stay to 96 hours.
8. Using 95-210 as a vehicle does not involve a time-limited demonstration authority, but rather provides communities with a sense of stability.

There are two additional sections I would recommend adding to 95-210 to further refine its use in targeting appropriate facilities.

1. Currently, 95-210 does not allow states to create additional conditions of participation in the Medicaid program. While this is good for free-standing providers, I would suggest that it would be appropriate to allow states to create additional conditions of participation for the expanded benefit to better enable each state to target the type of facility they wish to see develop into a new model.
2. It may be necessary for facilities that want to restructure into a new model to have capital for renovations and organizational development purposes. I would therefore suggest tying participation in the new benefit to having first received grant funds to develop a model appropriate to the specific needs of a community, and additionally require a state match on those grant funds to further enable states to target the facilities they believe to be essential access facilities.

Finally, I'd like to express my personal appreciation to the chairman and the committee for their efforts to limit the ability of physicians to profit from their referrals. I am most appreciative of those efforts both intellectually and as a consumer of health care. I would also like to express my appreciation to the chairman and the committee in exempting certain rural communities from some of those constraints.

As you are no doubt aware, in many rural communities, it is desirable for providers to consolidate, merge and develop joint ventures as a way of trying to maximize efficiency where volume is low. I would also like to go on record with my concern that the proposed safe harbor rules (42 CFR 1001), do not seem to show the chairman's understanding concerning the specific delivery issues in low-volume locations and the appropriateness of provider inter-relationships in those locations. I personally know of several isolated rural communities in which physicians are planning to leave the area if their small local hospitals will not acquire their practices. This is not competition, it is survival. In two of these cases, these are the only docs in town and in both cases, the acquisition has been put on hold because of the proposed safe harbor regulations. I would therefore urge the members of the committee to use their influence with the Inspector General to clarify this aspect of 42 CFR 1001 and provide a specific safe harbor for the merger of physicians and hospitals in isolated rural communities without the merger forcing the retirement of the physicians.

Once again, I would like to thank the committee for this opportunity to testify.

Chairman STARK. I want to thank the panel.

I guess it would be a fair summary that even if we did level the playing field, the first panel suggested that we would still have an awful lot of small rural hospitals that would be below the margin and would eventually work themselves into bankruptcy or need further subsidization. And it is not just dollars at the root of this problem.

Would you all accept that statement from your vantage point?

Mr. BERNSTEIN. There are a lot of hospitals that no matter what you do in terms of reimbursement will probably not make it. On the other hand, there are a lot of hospitals that will be able to make it, if they had reimbursement that was not affected by a rural versus urban factor but by a more sensitive wage indicator.

My worry about those hospitals is that there will be an erosion process that is very slow in terms of quality for hospitals that are needed.

Chairman STARK. Will you all ascribe the idea that there are hospitals we should maintain? It seems to me politically and whether that is the politics of elected officials or the politics of community pride and self-perpetuating boards, grandfather founded the hospital and his grandson or daughter is not going to let it fold on their watch. So there is a tremendous amount of community inertia that wants to keep institutions alive.

Maybe we ought to go back to cost reimbursement with these hospitals but couple that with decisions about what care is needed.

In other words, go on a strict necessity or planning basis, and then support the theory that that would be the most efficient way to take care of those areas, determine the level of high tech centers with a broader variety of services.

It is not a great number of beds, actually, but it sure is a nagging problem. That is the direction the Chair is inclined to go.

The only thing that seems to stand in our way is the political resistance that wants to keep everyone open. For those of you from rural areas, do we just have to swallow that, or is there something we can do to entreat people who want to change it? What can I do in North Carolina to make it a matter of community pride to get a referral center or a helo pad and convert the hospital?

Mr. BERNSTEIN. For most of the hospitals in North Carolina, equity is what they would like to have. For the little hospitals if there was enough financial incentive, I believe they would rather, with a good process, take those incentives and develop something different from an acute care inpatient facility.

Right now, those incentives don't exist. When we talk about 100- to 250-bed hospitals, they—and I think deservedly, want equity.

Chairman STARK. What about the 10- and 20-bed hospitals?

Mr. BERNSTEIN. I think if there was a package put together, they would take that.

Mr. ROSENBERG. Most of my work in California shows that they have retrofitted and they have sought creative relief.

Chairman STARK. They want to do helicopter pads?

Mr. ROSENBERG. They want to do something. If you don't change the participation, the problem becomes how do you structure those helicopters so that it is a point of pride for that community? I think that is a technical rather than a policy problem.

Chairman STARK. It is a very political problem. You have to call it the right thing so it looks like I would want it. Nobody wants to go home and tear the post office down.

Mr. ROSENBERG. We suggested it be called a primary care hospital.

Dr. CAPER. I think it is driven by reimbursement and not what the real needs are.

Chairman STARK. That is why I am hesitant to get into cost reimbursement unless we can limit the growth of it or we will be back in the soup we were in before PPS.

Mr. PICKLE, would you like to ask any questions?

Mr. PICKLE. Let me say, Mr. Chairman, the problems of the rural hospital are real and no community wants to be deprived of quality medical care. It depends on the circumstances whether you keep a hospital. But I rather imagine that in the days or years ahead, we will see the growth of small regional rural hospitals, not just a hospital in every rural city. It is not unreasonable to assume that.

I think these hearings bring this idea out and give us a chance to talk about it. This panel, I think, has been very interesting. I was not here to hear Dr. Caper, but I did hear the other two witnesses. They seem to think rural hospitals are generally underutilized.

I think Mr. Ross said the Federal Government can help the communities in this area, by addressing problems like rational health care, the level of Medicare reimbursement, assess to capital for renovation and incentives to keep physicians.

It is not just the reimbursement rates alone. It is a broader problem than that. I think we ought to measure each one of these hospitals on a broader basis.

Mr. BERNSTEIN, is it your belief, even with the alternatives for acute care hospitals in rural settings, that the current urban and rural payment differential should be eliminated?

Mr. BERNSTEIN. Yes, I think it should. I am not an expert on the formula. Maybe what needs to be looked at more is the factors that go into how specific the wage factor is in that formula, but rural or urban, I would say—

Mr. PICKLE. Are you saying we ought to change that formula, at least close the gap to a more reasonable point, no differentiation, if possible, if the facts support it?

Mr. BERNSTEIN. And provide enough incentive for little hospitals to do something.

Mr. PICKLE. Now, here is my question to you and to any of the panel. This committee is going to shortly be considering the Medicare budget for fiscal year 1990. We have got to make some harsh decisions, and we have got to know where we can shave Medicare to achieve this \$2.3 million reduction.

Let me ask you as a friend of the rural hospitals, can you tell me which revenue source is most critical for rural facilities, that PPS update, or the reimbursement for capital? Or is there something else? Anybody present want to try that? You obviously are hesitating as much as we are going to hesitate in our budget markup.

Mr. BERNSTEIN. PPS update would be my vote.

Mr. PICKLE. That is the most important. All right. That is interesting. I like the idea that there are different ways to go about it. We ought not to think only in terms of the differential for rural

communities who complain that it is what closes a rural hospital. There is a lot of other factors. Among others, they may not be using the rural hospitals, and low occupancy has got to be a major factor.

Incidentally, Mr. Chairman, I am the author here in the House of the bill H.R. 762, and it is a bill designed to give help to the rural hospitals and to close this payment gap, and to take other steps. I regret that I was not here this morning at the beginning of the hearing, because I wanted to outline broadly some of the aspects of that bill, but I had a meeting in Austin and couldn't get here until this afternoon.

At the conclusion of this next panel, Mr. Chairman, I would like to, for the record, outline some of the main points of the bill which over 100 Members in this House have sponsored already. So with your permission, at the conclusion of the next panel, I will outline some of that.

Chairman STARK. Without objection.

Mr. PICKLE. I don't know that I have got any other questions. I listened to Mr. Rosenberg, and I think your sentiments pretty much echo what Mr. Bernstein has said. We have got to look at this problem more than just one way, beyond the payment rate, and I think this committee has an obligation to do that. So I appreciate this panel coming.

Thank you, Mr. Chairman.

Chairman STARK. Thank you.

We want to thank the panel very much. We look forward to working with you.

Our next panel consists of witnesses representing rural hospitals. They are Joseph T. Engelken, the administrator of Community Hospital of Onaga, Inc., Onaga, KS; Cary M. Dougherty, president of the Medical Center of South Arkansas, El Dorado, AR.

As the witnesses are being seated I would like to recognize Mr. Pickle.

Mr. PICKLE. Mr. Chairman, our colleague, Mr. Anthony asked me if I would welcome Mr. Dougherty to the subcommittee hearing this afternoon. Mr. Anthony is unable to be present today because he is actually back in your home town of El Dorado, but he assured me that through your testimony the subcommittee will hear first hand the kind of things he has been advocating for several years. He wanted us to be sure to welcome you. He says you are one of the finest rural practitioners in the state.

Mr. DOUGHERTY. Thank you, Mr. Pickle.

Chairman STARK. Thank you, gentlemen.

Mr. Engelken, proceed.

**STATEMENT OF JOSEPH T. ENGELKEN, ADMINISTRATOR,
COMMUNITY HOSPITAL, ONAGA, INC., ONAGA, KS**

Mr. ENGELKEN. Thank you, Mr. Chairman.

My name is Joe Engelken. I am administrator of the Community Hospital in Onaga, KS. I have also submitted a written statement for the record, and with your permission, it will be part of the record.

Chairman STARK. Without objection, we will put your written statement in the record in its entirety.

Mr. ENGELKEN. With your permission, I would also like to highlight several points from that testimony and discuss Medicare and its impact on our rural hospital. Maybe it is my insecurity this afternoon, but the number—20 beds—keeps coming up, Onaga Hospital's number of staffed beds.

Chairman STARK. We hit it right on the noggin, did we?

Mr. ENGELKEN. Also, Mr. Chairman, I would like to thank you and the members of your committee for what—in sitting in the back of the room today—to me, looks like a very thoughtful and very honest approach at trying to come up with some sort of an assessment, some sort of a solution to this crisis.

I would be remiss if I didn't thank Congressman Jim Slattery, from our district, as well, for his genuine work in this effort.

My points:

Number 1, we of Onaga Hospital are at a point of crisis, and our feeling is it has something to do with occupancy. Our occupancy is currently running at 40 percent, which is about what it was in 1984. But we feel it has more to do with the uses we put those beds to.

Number 2, we feel this crisis has everything to do with equal pay for quality care of our Medicare patients, while meeting the same standard of care. Any Medicare patient deserves and needs and must expect that same sort of care.

In our own case, we are 23 miles from the nearest metropolitan statistical area, and in that respect, we are what Congressman Slattery would call a border hospital. That 23 miles amounts to \$250,000 to \$325,000 per year less reimbursement to our facility for the same appropriate care given to our patients by our doctors and the hospital staff.

The numbers are based on the following:

The Topeka MSA DRG rate is currently \$3,127. The rural rate, which affects us and every other rural facility in Kansas is \$2,373. This is a substantial reduction and what keeps coming up as equity this afternoon.

Meanwhile, because we are so close to our urban medical centers in Topeka, our nurse's salaries are dictated by the urban area, and our supply costs are substantially the same, if not more. Prior to 1984, we seldom ran even a minimal deficit. Our Medicare net income, or operating margin, has gone from 1984 at a plus 7.8 percent to a minus 27.2 percent in 1988. Ninety percent of our entire 1988 loss on operations was strictly due to the cost of Medicare patients. That is an important factor.

Our district fortunately has a good tax base, which was started in 1955. We have been able to provide some services as this Medicare deficit has cut a little deeper each year. However, we are near the end of our rope. Ironically though, we see hope, especially in light of your discussion this afternoon.

Steve Rosenberg just referenced Public Law 95-210. Using that as an example of hope, last November we started two hospital-based rural health clinics, which stem from that legislation. Those are Medicare certified hospital-based rural health clinics. This, to us, is an important form of experimentation, and I believe it is im-

portant as you move forward, to encourage that kind of experimentation and, as Representative Pickle said earlier, to encourage an array of approaches.

The point is, we want to compete. Our small Onaga 20-bed rural facility wants to compete, but we cannot when Medicare has been effectively subsidizing our primary competition for the last 5 years. We need time to heal that damage.

Number 3, do our elderly want a rural Onaga hospital? I would be biased if I didn't say yes, but let me explain why. We have fairly sophisticated rural elderly today who want a rural hospital, as any Medicare patient would want any hospital, to be closely linked to the appropriate facilities in order to assure a full cycle of care.

Our family physicians are one of the biggest driving forces in whether patients are triaged and admitted to our facility on an outpatient or an inpatient basis, or whether they are transferred to Topeka, which is Onaga's primary tertiary hospital link. This decision is made by the doctor with the patient 85 percent of the time, based on a survey.

I will give you an example of how this kind of a relationship can work very well—not only to the advantage of the tertiary hospital, but also to the advantage of Onaga Hospital. For example, our hospital does not do full hip replacements, we don't have an orthoped who will do full hip procedures. This patient must go to Topeka, periodically complaining to us and the doctor because of the necessity to transfer. Once they do get their full hip procedure done in Topeka, as quick as they can, they want to be transported back to our facility for skilled care or the followup rehabilitation.

A lot of physical and other therapy is involved in it, but basically this followup care, is a very legitimate element of primary care. This example shows potentially a very symbiotic relationship. The doctors play a key role in it. They want the same kind of quality, because their licenses are on the line just as does the hospital's.

Our rural elderly know if there is no rural hospital, you very quickly have no physician, and very shortly you have lost the infrastructure even for a helipad.

Number 4, rural hospital beds are used very differently from a tertiary medical center's beds. Oftentimes that is not reflected in the manner in which the occupancy statistics are presented to you; so our 40-percent occupancy means something different to us than it would to a tertiary facility.

For example, not included in this statistic are high use of 23-hour outpatient observation admissions. If you include these, our occupancy would rise to 44 percent. So there is a lot of play in those numbers.

Skilled nursing, as we just talked about, or swing beds, are another example. These beds get used for same day surgery, they get used for emergency care, they get used for a wide variety of other kinds of uses that go into the average 40 outpatient visits our hospital and doctors see every day, 365 days of the year.

Last but not least, two to three times each year every one of those 20 beds is full, and there may be a patient or two out in the hall when, for example, the latest influenza epidemic occurs. Like it or not, this is just a function of our high rate of elderly. Twenty-seven percent of our population is Medicare age, which I think is a

little better than double the national average. When an influenza outbreak occurs, it can have devastating consequences. Those beds are there for a reason on the inpatient side.

What I am trying to say is, one day we may have an emergency facility, the next day we may be full with acute care.

Five, we are working together with our neighboring hospitals. There are seven of us, in a rural group called Cooperative Coalition on Rural Health. We have accomplished a number of joint ventures together. We are experimenting with services that we can provide with cooperative satelliting, and last but not least, we all maintain close ties with our urban physicians and tertiary facilities, because we realize our limits.

The nature of medicine, the definition of medicine dictates these kind of limits these days. We have done a lot to develop alternative, appropriate services, yes, but it takes a good array of basic capital equipment. Whether you are looking at a holding-bed type setup, as Steve Rosenberg mentioned, or strictly an outpatient facility, or something less, you still need basic capital equipment for a good x ray unit, a good laboratory, those sorts of things. So regardless of what you do, a rural hospital is a capital-intensive venture.

Our nurses are cross-trained to be effectively their own subspecialists. For example, we are acting as a hospital field site with Washburn University of Topeka, to encourage them to treat rural nurse training as a specialty. We think this is important. You don't normally find a nurse in an urban tertiary center who knows the dynamics of rural nursing. A rural nurse has to be a lot of things to everybody, and this takes cross-training. That is also why we have to pay them well.

Number 6, those elderly who choose a rural lifestyle should not be penalized. By equity, what we mean for Onaga's hospital is the equivalent of \$700 more for each Medicare discharge this year, which totals \$110 per Medicare patient day. This is what we need going from where we are now to break even with our Medicare services.

Number 7. We don't think that closing rural hospitals will make it any less costly to Medicare to care for the same rural elderly. However, we do acknowledge it is important to experiment and it is important to look at alternatives. We want you to let us compete equitably and show you what we can do.

Number 8. Rural family physicians are reimbursed up to 50 percent less than their peers in Topeka. On the other end of the spectrum, urban specialists such as the orthoped I just mentioned, are reimbursed approximately 25 percent less if they come out to Onaga to perform a carpal tunnel or other orthopedic outpatient surgical procedure. So you have both ends being worked against the middle, and we don't feel it is fair. There should be incentives to encourage that orthoped to come out and provide appropriate-level care in our facility. We want that. Our elderly people want it, and it should cost Medicare less.

Physicians now base their practices where the hospital is located. This is a basic reality, one of the biggest limitations on the future of rural primary care facilities. You virtually cannot recruit a phy-

sician to a rural community if that community does not have a hospital. So that is our base.

On your question earlier of whether mileage or some other factors could go into determining the need for an access facility or emergency access hospital, I think it would be helpful to look at present family physician population bases, not just mileage, and determine what sort of population base can support a family physician.

You will probably find a hospital very close, if not in the same community, with the doctor based out of the same community.

Number 9, why not write off a 20-bed-staffed hospital with an average daily census of eight or, in our case, nine when including outpatient occupancy? For one, we are here now. There is a certain amount of startup inertia, lost capital, and time. We are here. We believe we are successful. If we can get equity, we can sustain.

We provide, as I said earlier, a wide range of care, ranging from emergency care to appropriate inpatient care of choice. Elderly rural people prefer to be, if they can, hospitalized in their community facility.

It is hard for me to listen to a statistical presentation, which jumps from State-to-State. When we are talking about emergency care, I am thinking of five recent specific patients whom the tertiary people from Topeka flew out on Life Start, landed at our hospital and said "had it not been for you, two of the five people 2 months ago that were seen in your emergency room, would have been dead. The helicopter would have meant nothing."

You have got to look at that. That is what people are worried about. There is such a thing as critical access, meaning minutes. The problem with rural hospitals, we feel, is not that all of our patients live in the country—sometimes we feel like Medicare treats us that way—we feel we have a much more personalized one-on-one philosophy of care. Our philosophy is not only attracting nurses from urban areas 50 to 60 miles away who want to work at our facility because they believe so strongly in this care, but patients also heal better, research has shown.

In summary, very quickly, please restore the option for a cost-based Medicare reimbursement. Let that be one of the options you look at—the sooner the better. In our case, this would be effectively the same thing as eliminating the urban-rural rate differential, but it probably would not always be the case in all situations with rural hospitals.

Number 2, implement a study period to evaluate and look at what kinds of creative things are being done around the country. Involve small and rural hospitals as much as possible. You will find that they generally very much have their heads screwed on right and believe very strongly in what rural health care is—when it is appropriate, and when it is time to come up with something new. I think you would be pleasantly surprised.

Number 3, correct the rural physician reimbursement inequity. This is a very critical leg of the stool.

Finally—Medicare is not responsible, we all know and agree, for subsidizing a declining rural hospital census, but it has a moral obligation, we feel, to reimburse equally for quality and appropriate care.

Thank you.

Chairman STARK. Thank you very much.

[The statement of Mr. Engelken follows:]

TESTIMONY OF JOSEPH T. ENGELKEN, ADMINISTRATOR
COMMUNITY HOSPITAL, ONAGA, INC.
ONAGA, KANSAS

BEFORE THE SUBCOMMITTEE ON HEALTH OF THE COMMITTEE
ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, D.C.

May 15, 1989

"THE PROBLEM WITH RURAL HOSPITALS IS ALL THEIR PATIENTS LIVE IN THE COUNTRY"

Onaga's Community Hospital thanks you for this opportunity to discuss the effect Medicare is having on us today and the very real health care crisis in our rural area. But first, I want to thank Congressman Jim Slattery for his genuine concern and work to alleviate this crisis.

Our hospital is now in crisis for several reasons:

1. ECONOMIC INEQUITIES:

We have been profoundly affected this decade by the farm crisis. As you know increased stress of any kind leads to increased physical and emotional illness, as well as accidental emergencies. In the Onaga area, we responded with increased community service in suicide prevention, psychological counseling, battered family support, and increased preventative education on safety and medical concerns. In a time when they could least afford it, our patients have required more intensive services. Today, Accounts Receivable and Contractual Adjustments continue to rise. In our mission as providers of quality medical care, Onaga Hospital is also a major employer and provides the "safety net" paycheck for many families in our service area.

2. DEMOGRAPHIC INEQUITIES:

Onaga's hospital has a primary service base of 7,500. It is 30 minutes to neighboring hospital and one hour to the nearest tertiary facility in Topeka. Our residents believe that a viable rural health care system is part of their community's lifeblood. This is especially important since 27% of our residents are Medicare age, twice the national average. We are there when the elderly farmer's tractor turns over, pinning him beneath it, or when the young farmer's wife goes into labor, or his father suffers cardiac arrest. Too many medical emergencies exist that could not be served in a facility more than an hour away without seriously endangering our patients' lives.

3. RURAL HOSPITAL REIMBURSEMENT INEQUITIES

This factor is now the most critical issue affecting our ability to remain competitive and viable. While our 23-bed hospital and 3 physicians are held to the same standards of care, for this identical care we are reimbursed by Medicare at a rate 25% less than our nearest urban hospital. Medicare patients comprise 60% of our hospital's daily census.

Our hospital's DRG base is almost \$1,000 less per patient admission than our adjacent urban hospital. Because we are a mere 25 miles beyond the boundary of this nearby MSA, we lose \$250,000 per year in Medicare reimbursement. In effect, our senior citizens and our hospital are being penalized \$10,000 for each mile beyond this MSA boundary.

At the same time, the urban facility effectively dictates the salaries of our nurses; and, our operating supply and capital costs are identical, if not greater. The result for our hospital is an annual operating deficit, which was not the case prior to the institution of the DRG's. In 1984, the first year of DRG's our hospital's Medicare operating margin was +7.8%; in 1988 it was -27.2%.

We support the new spirit of competitive excellence underlying PPS, but our rural hospital must also be equitably reimbursed to deliver competitively priced, quality medical care. Medicare's argument that our rural hospital is less expensive to operate is simply not true and it has not been true since 1984.

4. HUMAN RESOURCES:

Our hospital competes intensely to recruit and retain professional staff, like everyone else. Without physicians, nurses and ancillary staff, there is no hospital. There isn't even the basis for a helipad. Until the early 1980's, a rare staff vacancy would be filled within 2-4 weeks. As nursing and ancillary wages have risen and people have become very mobile, the competition for a shrinking labor supply has become overwhelming. In 1984 our average RN labor costs were \$9.35/hour; in 1989 so far is \$14.00/hour, a 50% increase. Last week a Topeka hospital again raised the starting RN salary \$1.00/hour. We will feel the repercussions immediately.

5. RURAL PHYSICIAN INEQUITIES:

Our physicians and surgeons meet the same standards of education, expertise, and malpractice coverage as their urban colleagues. Yet sixty minutes away physicians make up to 50% more for the same kinds of care.

For our rural hospital to sustain itself, our three family physicians must be reimbursed equitably by Medicare. The loss of one physician means our hospital has lost its critical mass. This leads to a host of additional problems, such as practice stresses and chronic turnover and decline.

6. CROSSROADS:

Onaga Hospital has experimented successfully with several new services in our primary service area in this decade, for example:

- Our focus on outpatient services began in 1982
- Daycare Center for Employees' Children (1984)
- Labor & Delivery Birthing Center (1981), and LDRP Birthing Suites (1989)
- Mini-Rehabilitation Unit (3 beds, 1988)
- Hospital-Based Rural Health Clinics (2 in 1988)
- Strong Professional Education/Development Component ("Growing our Own")
- Computerized Hospital System via Carl Perkins Grant (1985)
- G.O. Bond Approved to Enlarge Outpatient Services (1988)
- Future: Rural Hospital as a Continuum-of-Care Mini-Center (Hopefully)

But we are at a crossroads. On one hand we have to be a miniturized model of our urban friends in Topeka, because our patients expect, deserve, and require the same quality of care. On the other hand, Medicare seems to be telling us, from a financial standpoint, this cannot and will not be the case.

The loss of a small hospital may not at first seem important. But consider yourself working in a hazardous occupation with heavy farm equipment sixty miles from the nearest medical facility. Or consider what a sudden pain in your chest might mean when you are several hours from the nearest physician—a doctor you have never met and who has never met you. A viable rural health care system cannot begin and end with a helipad.

And who will be accountable for the absence of quality rural health care? Who will tell the 7500 people living in our rural service area that their 40-year-old bear, or their 3-year-old child with an acute asthma attack are less important simply because they have chosen a rural lifestyle? And, do you think that our rural elderly will be better cared for—or for less cost to Medicare—by standing by and watching rural hospitals close and doctors leave? We do not believe that the problem with rural hospitals is only that all their patients live in the country.

SUMMARY RECOMMENDATIONS:

1. The FPS system does not work for Rural Hospitals. We ask that you quickly restore the option for a cost-based Medicare reimbursement system. We ask that you take action now, including an immediate study of these issues. It is critical that you give rural community leaders enough breathing room to discuss the future of their health care infrastructure.
2. Eliminate the urban-rural rate differential immediately.
3. Refocus Medicare's policies and procedures to correct the underlying urban regulatory bias. One example, an orthopedic surgeon should be able to be reimbursed the same amount for seeing a patient in our rural community as they would if seeing that same patient in Topeka. This would encourage better rural specialty coverage.
4. Correct rural physician reimbursement inequities immediately. This is the critical reason why doctors are reluctant to open practice in rural, high-elderly communities. (No Doctor - No Hospital)
5. While Medicare is NOT responsible for subsidizing declines in a rural hospital's census, it has a moral obligation to assure equal care for our rural elderly. To assume that a two-tier system of health care is the only possible blanket solution to this challenge is immoral and unjust.

Thank you for your sincere interest and commitment to the preservation of rural hospitals and health care services.

Chairman STARK. Mr. Dougherty.

STATEMENT OF CARY M. DOUGHERTY, JR., PRESIDENT, MEDICAL
CENTER OF SOUTH ARKANSAS, EL DORADO, AR

Mr. DOUGHERTY. Thank you, Mr. Chairman.

My name is Cary Dougherty. I am the president of the Medical Center of South Arkansas, El Dorado, AR, a 320-bed rural hospital presently designated as a rural referral center for purpose of Medicare reimbursement. My hospital is also a member of the Rural Referral Center Coalition, an informal group of approximately 90 hospitals that are RRCs and PPS.

We support the proposed legislation that would maintain the status quo under Medicare with respect to current RRC reimbursement and eligibility. We support legislation which seeks to reform PPS generally to address the needs of all rural hospitals, such as the legislation Representative Pickle spoke of earlier.

Today's rural health network includes both small rural hospitals, which generally provide essential primary care services, and larger rural hospitals which are essentially serving as referral centers to other rural hospitals and thereby provide necessary secondary and tertiary level services for rural populations.

All rural hospitals currently are distressed under Medicare's PPS system. Forty-three rural hospitals shut their doors in 1988. As a result, the picture of the rural health network is changing. RRCs are by necessity, assuming more of a role as a primary care provider and thus, even more so, we are the linch pins of the rural health network.

This year RRC designation entitles hospitals to receive 11 percent higher Medicare standardized amount than other rural hospitals. This is intended to cover the additional costs of providing the more specialized care. Indeed, in order to properly treat more severely ill patients, RRCs incur higher costs than do other rural hospitals. Sicker patients demand advanced technologies, a broad range of drugs and supplies, and specialized medical staffs and personnel.

Accordingly, when PPS was first initiated, Congress provided for a special payment provision for RRCs to ensure adequate reimbursement. There has been a general misconception since the enactment of PPS that RRC reimbursement is overly generous. The consulting firm of Lewin-ICF recently found that HHS reports that RRCs are being overpaid are inaccurate because they are based on outdated data and old reimbursement methodologies.

My hospital's experience with Medicare costs attest to the Lewin-ICF conclusions. Our current Medicare operating margin is negative 16 percent.

This year RRCs face two problems which can be solved legislatively:

First, a provision included in OBRA 1986, which permitted all designated RRCs as of October 21, 1986, to maintain RRC status expires October 30, 1989. HCFA estimates that 25 percent of the 226 RRCs will lose their status if this grandfather provision is not extended. Three of those are in my State of Arkansas. Consequently, these facilities will face enormous financial obstacles to continue

provision of vital secondary and tertiary care services to rural areas.

The grandfather provision should be extended, because the current criteria for RRC status needs to be reevaluated. Indeed, OBRA 1987 mandated that HHS submit a report to Congress by March 1989 regarding appropriate criteria and payment rates for RRCs. This report has not yet been submitted. It is no longer appropriate to use criteria drafted before the implementation of PPS, since PPS has resulted in new realities for the hospitals.

For instance, my hospital's case mix indices are decreasing now as we serve more primary care patients because local rural hospitals near us have closed.

Also, given that the validity of the urban-rural differential underlying PPS is currently being challenged, it would be arbitrary and unfair to single out RRCs for reduction pending a possible revamp of the whole PPS system. This would be especially shortsighted given the likely restructuring of rural health care to rely more heavily on RRCs for all levels of care.

Finally, enactment of the legislation would require no new revenues, since it would maintain the status quo. HCFA now estimates a \$20 million Medicare savings in fiscal year 1990 if the grandfather status expires. Not only is this a relatively insignificant figure, it is also likely an overestimate of actual savings given that the effected RRCs will have to terminate specialized services and be forced to refer patients to urban institutions, whose costs of providing the same services is even higher.

A second problem is that the wage index for all rural hospitals is disastrously inadequate. Presently, the rural wage index does not reflect a hospital's cost of acquiring and retaining health care professionals. Accordingly, we support proposed legislation which would require that wages be calculated based on regional rather than local data and factor in different wages paid professional and nonprofessional staff to be updated annually.

We also support provisions which would maintain current reimbursement for RRCs as well as those that would establish a Medicare geographic classification review board so that rural hospitals can make a case for receiving the applicable urban standardized amount and/or wage index.

Finally, we are concerned about recent proposals to alter capital payments to hospitals to be based on occupancy levels. This would be contrary to Congress' intent to offer rural hospitals additional support in these dire times. We urge that Congress explore all possible options before pursuing this proposal.

I thank the committee for your time and would be happy to answer any questions.

[The statement of Mr. Dougherty follows:]

TESTIMONY OF CARY M. DOUGHERTY, JR.
MEDICAL CENTER OF SOUTH ARKANSAS

I am the President of the Medical Center of South Arkansas, El Dorado, Arkansas, a 302 bed rural hospital, designated as a rural referral center ("RRC") for purposes of Medicare reimbursement. My hospital also is a member of the Rural Referral Center Coalition, an informal group of approximately 90 hospitals that are rural referral centers ("RRCs") under the Medicare prospective payment system ("PPS"). The Coalition has formed to serve as the unified voice to address the critical issues facing RRCs under PPS. I and the Coalition support proposed legislation (H.R. 690, H.R. 762, H.R. 1583, H.R. 2246) that would maintain the status quo under Medicare with respect to current RRC reimbursement and eligibility and we support the House Rural Health Care Coalition's legislative package and H.R. 762 where these measures seek to reform PPS generally to address the needs of all rural hospitals.

Today's rural health network includes both small rural hospitals which generally provide essential primary care services, and larger rural hospitals which essentially serve as referral centers for other rural hospitals and thereby provide necessary secondary and tertiary care services to rural populations. All rural hospitals currently are in distress under Medicare's PPS system. Almost 60% of the administrators of rural hospitals believe their institutions are vulnerable to financial failure. In fact, 43 rural hospitals shut their doors in 1988. As a result, the picture of the rural health network is changing. RRCs are, by necessity, assuming more of a role as primary care providers. For instance, when a local rural hospital closed recently, my institution necessarily became the site for primary care services previously available at the other hospital. At the same time, my hospital continues to serve the essential role of providing secondary and tertiary care services. At this time, my hospital is designated as an RRC, and thus is entitled to receive more Medicare reimbursement than other rural hospitals; this additional reimbursement is intended to cover the additional costs of providing more specialized care. Given the changes in the delivery of care in rural settings, the necessity of preserving RRCs, the linchpins of the rural health care network, is even more compelling.

BACKGROUND ON RURAL REFERRAL CENTERS

In enacting the original PPS legislation, Congress specifically created a category of "regional" or "rural" referral centers in recognition of the fact that some rural hospitals provide specialized health care services which entail greater costs than other rural hospitals' services. More specifically, Congress recognized that the costs per case of these hospitals were likely to be closer to those of an urban hospital than to those of a typical rural hospital.

RRCs treat more severely ill patients and receive cases that tend to be more complex, and thus more costly, than those in the average rural hospital. RRCs have a higher case mix, not just among all DRG categories, but also within DRG categories. Further, the sicker patients who travel greater distances to larger, more specialized hospitals demand advanced technological services and a broader range of drugs and supplies than are needed in other rural hospitals. RRCs must have the necessary facilities and equipment to provide these specialized services. Moreover, the fixed costs for these facilities is usually spread across a smaller group of patients resulting in higher per case costs.

RRCs also have higher labor costs than other rural hospitals because of the need for more specialized care. For example, if a community had two hospitals, one of which was an RRC, the average hourly rate in the RRC would likely be higher because of the need for more specialized personnel. Specifically, highly trained personnel are needed to operate the sophisticated high technology equipment such as MRI devices and cardiac catheterization units commonly found in RRCs.

Moreover, in some instances, RRCs' labor costs actually exceed those of urban centers in order to attract specialized personnel. For instance, in order to secure their employment, my institution pays some allied health professionals 25% more than they would receive in Little Rock or Dallas.

Further, the medical staffs at RRCs must include a wide range of specialists to treat the variety of secondary and tertiary conditions presented by the patient population. RRCs thus must dedicate additional fiscal resources to attract and maintain specialty staffs.

Congress was aware that these differences might result in systematic underpayment to RRCs under PPS were they to be reimbursed at the same level as other rural hospitals. Therefore, special payment provisions were developed for RRCs to prevent reductions in access to specialized care among the non-urban population.

Presently, in order to qualify for RRC status, a rural hospital must have at least 275 beds and be located in a designated rural area, or be located in such an area and meet each of three criteria set forth in regulations published by the Health Care Financing Administration ("HCFA") in the Department of Health and Human Services ("HHS"). First, its case mix must be equal to, or greater than, the lesser of the median case mix index for all urban hospitals nationwide or the median for non-teaching urban hospitals in their census region. Second, it must have a minimum of 3,000 discharges or the median number of discharges for urban hospitals in its census region. (Osteopathic hospitals need only have 3,000 discharges per year). Third, it must meet one of three additional criteria relating to physician specialty and referral patterns.

HCFA further determines reimbursement methodologies for RRCs. Currently, hospitals that qualify as RRCs are reimbursed based upon the standardized amount applicable to "other urban areas" (e.g., those with a population of less than one million). For FY 89, the "other" urban rate is only 11% higher than the rate for rural areas. For FY 1990, this payment difference may be even smaller if Congress provides for a higher update for rural hospitals than for other urban hospitals. The standardized amount is then adjusted for differences in area wages using the wage index applicable to rural areas in the state in which the RRC is located.

Currently, approximately 226 hospitals are designated as RRCs. According to PropAC, RRCs comprise 4% of all hospitals, receive 5% of all PPS payments, and account for 6% of all Medicare discharges.

Pursuant to OBRA '86, all rural hospitals which were designated RRCs as of October 21, 1986 maintain such status through the end of their respective fiscal years beginning before October 1, 1989 (the "grandfather period") without undergoing continuing scrutiny to determine satisfaction of the RRC criteria.

CONCERNS REGARDING RRCs

There has been a general misperception since the enactment of PPS that RRC reimbursement is overly generous. Much of this stems from reports from HHS and its Office of the Inspector General ("OIG") which have concluded that while RRCs are more expensive to operate than other rural hospitals, they are not as costly to operate as urban hospitals. Thus, the reports assert that RRCs are being overpaid and recommend using a lower standardized amount than the full urban rate in calculating RRC payments.

Because the members of the Coalition did not believe the HHS or OIG reports accurately reflect the experience of RRCs under PPS, the Coalition asked the Lewin/ICF consulting firm to examine the reports and conduct an independent analysis of the experience of RRCs under PPS.

The Lewin/ICF report, issued in February 1989, concluded that these studies, in fact, do not accurately reflect the experience of RRCs under PPS. Lewin/ICF identified several fundamental problems with the reports. For example: (1) they use data from the first few years of PPS and therefore do not reflect the more recent experience of RRCs under PPS, which has been much worse; (2) they do not consider the fact that under OBRA '87, RRCs are now reimbursed at the standardized rate for urban hospitals located in regions with less than one million inhabitants, which rate has been consistently lower than the rate for urban hospitals in large metropolitan areas; and (3) while costs per case were compared, the reports did not examine operating margins which reflect not only costs, but also Medicare payments or revenues which are on average lower for RRCs because lower wage rates in rural areas are reflected in the wage index used to calculate payments. The Lewin/ICF report also found that:

Such comparisons fail to account for the lower revenues that RRCs receive, primarily as a result of the wage adjustment incorporated into PPS. Furthermore, past studies have focused on cost per case when a comparison of Medicare operating margins would be more valid. Indeed, in FY 1987 for example, RRCs had Medicare operating margins that were lower than urban hospitals as a whole and substantially lower than hospitals in other urban areas. Medicare operating margins in FY 1989 and 1990 are estimated to be negative for all hospitals groups. For RRCs, Medicare operating margins are estimated to be negative 16% in FY 1989 compared to negative 26% for all hospitals.

My hospital's current Medicare operating margin is negative 16%. As an example of the costs to my institution of serving Medicare patients, in February our census was 141, with a net operating loss and in April our census was 120 with a net operating profit; not surprisingly, the Medicare population of patients served in February was much greater than that in April, accounting for the loss in February despite a higher census. Indeed, while 42% of our patients are Medicare beneficiaries, they account for 50% of our charges.

Finally, the Lewin/ICF report concluded that RRC costs are comparable to those of hospitals in "other" urban areas -- that is, those with less than 1 million population -- and thus RRC payment based on the other urban rate continues to be justified.

This report should lay to rest any lingering concerns that RRC reimbursement is excessive. To the contrary, RRCs, like all other hospitals, are faring poorly under PPS.

SUPPORT FOR PENDING LEGISLATION

Sixty-seven Representatives to date are co-sponsors of H.R. 680, ninety-seven Representatives to date are co-sponsors of H.R. 762, seventy-one Representatives are co-sponsors of H.R. 1583, and one Representative is a co-sponsor of the recently introduced H.R. 2246, all of which would extend the current grandfather period for RRCs and prohibit HHS from changing RRC reimbursement (H.R. 680 and 762 do so until October 1, 1994, H.R. 1583 does so until a single national standardized amount is established for all hospitals, and H.R. 2246 does so until October 1, 1991.) We believe there are several compelling reasons to enact legislation which accomplishes this end.

First, the criteria which qualify hospitals for RRC status need to be reevaluated; until this is accomplished, all currently designated RRCs should maintain their status under Medicare. As early as 1986, it became clear that the hospital marketplace was changing dramatically with possible repercussions for criteria which would entitle a rural hospital to special treatment under Medicare. For instance, as the efficiency incentives under PPS were fully implemented, many hospitals began to see patients on an outpatient basis, thus reducing the number of discharges. In communities where smaller rural hospitals shut their doors, some RRCs found that their case mix index decreased as they began to handle the primary care cases that previously went to the hospitals that closed. My institution's case mix has decreased directly because of the closure of a nearby rural hospital. Convinced that the original rationale that merited special treatment of RRCs was still valid, Congress decided, during the enactment of OBRA '86, to grandfather all RRCs then qualified through hospital cost reporting periods beginning before October 1, 1989. In the interim, Congress expected that HHS would work with the hospital industry to determine new, appropriate standards for RRCs.

In order to assure that this issue was fully considered, Congress, in enacting OBRA '87, specifically required that HHS submit a report to Congress regarding the appropriate criteria and payment rates for RRCs. This report was due by March 1, 1989. Unfortunately, the HHS report has yet to be submitted to Congress. Accordingly, many issues regarding RRC criteria remain unresolved, including:

- o How have six years of PPS influenced the provision of, and access to, specialty care in rural areas?
- o What criteria should now be used to justify a payment differential to providers of such services?
- o How many hospitals would qualify under any such new criteria?
- o How many current RRCs would not qualify under such new criteria?
- o What impact would the loss of the RRC reimbursement differential have on the availability of health care services and the number of jobs in rural communities now served by RRCs?

Unfortunately, these are all important questions to which little attention has been given. Although HCFA has recently estimated that 25% of all RRCs (e.g., about 60) will lose their status should the grandfather provision lapse, it remains unclear as to exactly which hospitals will be affected. Moreover, it is still unclear what criteria, if any, might be considered to replace the current ones. It is no longer appropriate to use criteria crafted before the implementation of PPS, given the fact that PPS has resulted in new realities for rural hospitals. For instance, as discussed above, RRC case mix indices are decreasing as RRCs serve more primary care patients whose local rural hospitals have closed. Unless the criteria are revised dramatically, institutions like mine will be dissuaded from adding new and important services, which may further decrease the case mix. For example, my hospital is struggling to decide whether to hire an additional medical oncologist, because doing so will increase our chemotherapy admissions with an associated case mix index of only .4742. Moreover, the arbitrary 275-bed criterion places additional constraints on hospitals which are contemplating re-organization to provide services more effectively. My hospital is refraining from converting acute care space to needed alternate care programs, such as skilled nursing beds, out of fear of falling below the 275 bed threshold. Until the uncertainties as to the appropriate RRC criteria are resolved, RRCs should retain their status. Indeed, Congress' intent to maintain the status quo until it had the opportunity to adequately reevaluate RRC criteria remains valid today.

Second, given that the validity of the urban-rural differential underlying PPS is currently being challenged, it would be arbitrary and unfair to single out one group of hospitals (i.e., RRCs) for reductions pending a possible revamp of the whole PPS system. To the extent that the urban-rural differential is phased out (and assuming appropriate adjustments and hold harmless provisions are adopted), there may no longer be a need for the RRC category. However, in the interim, and unless and until these questions are addressed, we believe that allowing hospitals to lose their RRC status would only take a payment system that is already unfair to rural hospitals and make it worse.

Finally, and importantly, enactment of the legislation would require no new revenues, since it would maintain the status quo. In contrast, HCFA estimates that RRCs which would lose their status in FY 1989 if the grandfather period is not extended would lose a total of \$20 million in Medicare payments. (See May 8, 1989 Federal Register, at page 19636 and following.) Not only is this an insignificant amount of "savings" to Medicare, it also likely is an overestimate of actual savings given that the affected RRCs will have to terminate specialized services and be forced to refer patients to urban institutions whose cost of providing the same services is even higher. For instance, if my hospital loses RRC status, we will lose \$1.3 million in Medicare reimbursement. This dramatic loss will severely threaten our ability to provide the radiation and medical oncology, Level II perinatal and neonatal care, neurology and non-invasive cardiology, and other diagnostics services which we now offer to our patients. Nonetheless, these patients will continue to demand these services and will have to incur expenses to travel to more costly urban hospital settings. In some instances, Medicare will have to pay for the transportation as well as the health care costs. Accordingly, HCFA's projected \$20 million "savings" should be offset by the inevitable increased costs which will result from serving many patients in urban settings who otherwise would be cared for in RRCs.

We would emphasize that time is of the essence for legislative action on this issue, whether the above-cited bills are enacted independently or as part of a budget reconciliation package. The current grandfather provision expires as of October 1, 1989. Thus, hospitals with cost reporting periods beginning October 1, 1989 may be in jeopardy of losing their RRC status as of that date if the grandfather provision has not been extended by then. Loss of RRC status will result in a devastating reduction in the reimbursement which now permits RRCs to offer a wide range of needed specialty services in rural areas. Further, expiration of the grandfather provision will result in a significant loss of jobs as well as services, which will only exacerbate the problems with the delivery of health care in our rural communities.

Several hospitals face the dilemma of not knowing whether they will lose 11% of their Medicare standardized payments as of October 1. It is extremely difficult for these facilities to plan and to make commitments to services and staff in the face of this uncertainty. For instance, RRCs will be dissuaded from dedicating resources to recruitment efforts and will be hard-pressed to attract specialists given an environment of constant uncertainty as to the continuation of Medicare reimbursement at its current, albeit inadequate, level. Rural health will suffer dramatically as a direct result. We would urge the Committee to expedite this legislation to avoid that outcome.

AREA WAGE INDEX

Presently, Medicare reimbursement to all rural hospitals is calculated using a rural wage index for the rural areas in any given state. These bases do not reflect these hospitals' costs of acquiring and retaining health care professionals. We support the concept behind a provision in H.R. 2246 which would

require that wages be calculated based on regional, rather than local, data and factor in the different wages paid professional and non-professional staff, to be updated annually, so that all rural hospitals can be reimbursed based on the realities of the wages which they must pay to attract and maintain staff. My hospital has suffered a serious decline in our applicable wage index which now stands at .7124, compared to .8294 when PPS was first instituted. As a direct result, many of our personnel had not even been awarded a cost of living increase several consecutive years.

Moreover, the Lewin/ICF study examined the issue of wages paid by RRCs to wages paid by other hospital groups. This analysis suggests that wage rates for RRCs are similar to those of other urban hospitals. In 1984, the wage rate for RRCs was \$9.58 per hour, while the wage rate for other rural hospitals was \$7.84 per hour. The wage rate for RRCs was 5% lower than for large urban areas, while virtually identical to that for hospitals in other urban areas. Accordingly, there does appear to be justification for paying RRCs based upon the applicable urban wage index. Towards this goal, the Coalition supports the provisions in H.R. 762 that would establish a Medicare Geographic Classification Review Board. Under these provisions, a rural hospital, including a rural referral center, that believes it can present a case for receiving the applicable urban wage index would be allowed to appeal to this newly created board. We believe many RRCs would be able to present a very compelling case in this regard. We would urge that the legislation be clarified to assure that RRCs are eligible to avail themselves of this provision.

CAPITAL REIMBURSEMENT

Finally, we are concerned about recent proposals to alter capital payments to hospitals such that they are based on occupancy levels. Such a structure would be contrary to Congress' intent to offer rural hospitals additional support in these dire times, given that such hospitals' Medicare reimbursement likely would suffer as a direct result. We urge that Congress explore all possible options before pursuing this proposal.

CONCLUSION

The Committee should adopt provisions which would extend the grandfather provision and retain current RRC reimbursement levels, at least until the urban-rural differential is phased out.

8322C

Mr. PICKLE. Mr. Dougherty, I appreciate your comments. I know that Mr. Anderson has been very interested in maintaining the strength of the rural referral centers. What would it mean to these institutions to live with the possibility that you might lose your RRC designation this year, that it would expire?

Mr. DOUGHERTY. It is doing a couple of things to us. It is distorting our strategic planning. We are overly worried about the 275-bed level above which we are designated as rural referral centers, and it is interfering with our ability to properly evaluate restructuring our services and perhaps reducing the availability of acute care beds in our hospital.

We also are considering adding new specialties, for example, medical oncology. However, if we add medical oncology, the most common case mix they admit is chemotherapy with a case mix index of 0.47 and that would reduce our overall case mix.

Mr. PICKLE. You lose your classification then?

Mr. DOUGHERTY. Yes. If we would lose it, the services that will be cut will be the expensive, high tech services, such as level two perinatal, and neonatal ICU, neurology, neurological testing, cardiology, radiation, and medical oncology. These are patients that have been identified in the system, they have already accessed the system, and they will be sent to an urban center, where they will be treated at a higher cost.

Mr. PICKLE. What is your hospital's experience with the so-called rural wage index?

Mr. DOUGHERTY. Our experience is that it is a ceiling on wages, a very oppressive ceiling. We started out with a wage index of approximately 0.82 and over the past 8 years, we have been ratcheted downward to a 0.71, and it is a real oppressive ceiling on us.

We have hospitals from Louisiana—we are close to the Louisiana border—come up and rent a room in a local hotel for a week and recruit our nurses. In specialty services, where the allied professional technician may be particularly in short supply, we know we pay 25 percent higher than Little Rock or Dallas, which are some of our big recruiting markets. But because we have the wage index ceiling, we have less total money than urban hospitals to pay all our employees, and to pay any employee a little bit more to attract them, we must cut someone else.

Mr. PICKLE. Well, help me understand your situation. What is the size of—is it South El Dorado or are you a part of a major city, or what?

Mr. DOUGHERTY. El Dorado is the largest city in south central Arkansas, but it is not large by any standards. It is 26,000. We are about 2 hours drive from any other alternative acute care.

Mr. PICKLE. I assume that there are other little cities right around there?

Mr. DOUGHERTY. There are. About 40 to 45 miles east, north, and west of us are other cities of 12, 16, and 15,000.

Mr. PICKLE. Can you then account for—did you say 274 beds that you actually have in that hospital, or you can go up to that amount?

Mr. DOUGHERTY. We have 302 beds now licensed.

Mr. PICKLE. You mean 302 beds that are actually available based on the size of these cities?

Mr. DOUGHERTY. No; we have 302 beds available in El Dorado, AR.

Mr. PICKLE. What do you mean by 30% available. There are that many beds in that hospital?

Mr. DOUGHERTY. Yes, sir.

Mr. PICKLE. Did you build it as a rural referral center?

Mr. DOUGHERTY. That designation was not in use at the time the hospitals were built, but we had two hospitals in that town which we have merged. We recently merged them, just last year. So that is the combined total of the two merged hospitals.

Mr. PICKLE. You can't have a hospital with 274 beds in El Dorado unless you built it for all the cities around there.

Mr. DOUGHERTY. We have. We feel like our service area is close to 150,000. It includes these other smaller cities plus the country population.

Mr. PICKLE. I am just looking at it with the idea that if you reach the point where you cannot have a hospital in every rural community, you have to find some central referral hospitals.

You built a hospital in anticipation of giving service to 50 or 60 miles all around. That would be the equivalent to 274 beds?

Mr. DOUGHERTY. That is correct.

Mr. PICKLE. That is very interesting.

Mr. Engelken, when you described your hospital, I could not help but think that those facts describe the situation in a town in my district called Bastrop, TX. We had one hospital close last year. Thinking back many years ago, I was a relatively young and new Congressman, and I helped get the hospital in Bastrop. They thought they were in heaven because they had a new hospital. It closed last year. It was rather modern, but it was not used.

Now another one in Lockhart, 20 miles away, is in danger of being closed. The same thing is happening all over the country.

We have to decide on the best way to save them. What you described in that little community, Onaga, is just about the same situation.

You have 23 beds and 60 percent are Medicare. Those in my district are not much different from that. So when you recommended the restoration of the option for cost-based Medicare reimbursement and eliminating the urban-rural differential and refocusing the policies to correct the underlying urban-rural bias in order to correct the inequities, I think you do make a case that we, the government, Federal and State together, do have a moral obligation to see that rural people get as high quality care as the urban resident.

We can't say, well, you are in a rural area, tough; you have to go to a big city to get care. It is not an easy problem to settle.

Your description of the Onaga community hospital is exactly what is happening in Lockhart, TX, or is about to happen. I was there this weekend. One of the board members said, "We're just hanging on." That was a fearful sort of an observation to be told out of the blue, but it is a fact.

I don't know what we can do about it. We have to make some changes.

I personally appreciate your testimony.

Mr. ENGELKEN. In a way we are hanging on, too. But we know that you are going to make the right decision and equity will be restored.

On that basis, then we will have enough time to let our communities address the desired future that we want.

Chairman STARK. I sure wish the AMA shared your optimism about this subcommittee.

Mr. ENGELKEN. You said something today about physicians and hospitals. I think it is important to go on record that in a rural community, the doctor and hospital are part and parcel of health care. This stems very much from the comments Steve Rosenberg was making a little while ago. I can't stress it enough that the two do work hand and glove. It's because we work together. On the one hand rural physicians, if they feel that quality of care is being jeopardized, then there will be a change. Then the community hospital will change, and community leaders would certainly go along with that change, if that time comes.

But our concern, and the word I was asked to convey to you from my physicians and board, is that the time is not here yet because we have not had a chance to see what equity will do. Medicine is changing so rapidly, and there are a lot of positive things taking place in the growth of medicine—the evolution of medicine, I should say—which are very favorable to rural facilities.

Chairman STARK. I would like to see if we can help.

Thank you both for your testimony today. We appreciate it very much.

Our own Mr. J.J. Pickle is going to enlighten us.

Mr. PICKLE. You were kind to allow me to come in late this afternoon. I had hoped to be here earlier.

Earlier this year I introduced H.R. 762, the Equity for Rural Hospitals Act of 1989. This is the same bill as the one introduced in the Senate by Senator Bentsen. We have 100 Members who cosponsored this legislation, many of whom are members of the Rural Health Care Coalition.

I want to highlight three or four points here today. I would like to have your permission to insert the explanation of the various sections of the bill so it will be in the record.

Chairman STARK. Without objection.

[The information follows:]

EQUITY FOR RURAL HOSPITALS ACT OF 1989—SUMMARY OF PROVISIONS

SECTION 1: SHORT TITLE

The short title of the bill is "The Equity for Rural Hospitals Act of 1989."

SECTION 2: ELIMINATION OF AVERAGE STANDARDIZED AMOUNTS FOR HOSPITALS DIFFERENT AREAS AND CREATION OF SEVERITY ADJUSTMENT

The Secretary of HHS would be required to design a legislative proposal to eliminate Medicare's current differential between payment rates for hospitals in rural, large urban and other urban areas. The proposal would include a four-year transition to a single national rate beginning in fiscal year 1992, with a single national rate fully in effect by fiscal year 1995.

The Secretary would be required to include recommendations for any changes in Medicare's current special treatment of teaching hospitals, rural referral centers, sole community hospitals, disproportionate share hospitals and outlier cases.

The Secretary would be required to recommend a severity adjustment to reflect the differences in severity among cases in the same diagnosis-related group, and any other adjustments deemed appropriate (including changes in the treatment of hospitals exempt from PPS).

The Secretary's report, which would include extensive impact analyses of the effects of the proposal on different types of hospitals, would be due to Congress on October 1, 1990.

The Secretary's report would be reviewed by both the Prospective Payment Assessment Commission and the Congressional Budget Office. Each will submit a report and impact analysis to Congress by April 1, 1991.

SECTION 3: INTERIM PROVISION TO ENSURE ADEQUATE PAYMENTS FOR INPATIENT HOSPITAL SERVICES FURNISHED BY MEDICARE-DEPENDENT, SMALL, RURAL HOSPITALS

For a two-year period (FY 1990-91) rural hospitals with 100 or fewer beds and dependent on Medicare for more than 70% of inpatient hospital services, would receive an additional payment to ensure that total payments for inpatient hospital services would be at least equal to the reasonable costs of those services for Medicare patients.

In defining reasonable costs, the Secretary could not impose limits based on the average costs incurred by hospitals (formerly known as Section 223 limits).

Hospitals receiving these payments would remain on the prospective payment system, and any periodic interim payments made to them would reflect an estimate of additional payment amounts.

SECTION 4: MODIFICATIONS WITH RESPECT TO SOLE COMMUNITY HOSPITALS

Beginning October 1, 1989, Medicare payments to sole community hospitals would be changed. Under current law, SCHs are paid three-fourths on a basis which reflects their own hospital-specific costs in a base year, trended forward, and one-fourth on the basis of the applicable regional PPS rate.

Under the legislation, the three-fourths hospital-specific cost basis would be updated by the Secretary of HHS using more recent information on the SCH's cost per case; however, SCHs would be held harmless from any reductions below their current hospital-specific costs. Further, under the bill, a SCH's one-fourth PPS rate would be based on the higher of the applicable national or regional PPS rate.

The Secretary would also be required, in setting criteria for qualification as an SCH, to take into account travel time to the nearest available source of appropriate inpatient care. (Current criteria take into account only the travel distance). Also, if the Secretary chose to use criteria related to an SCH's market share, he or she would be required to take into account the extent to which patients go outside the local market area to seek unavailable services. (Current criteria do not always allow for this factor to be taken into account).

SECTION 5: ESTABLISHMENT OF MEDICARE GEOGRAPHICAL CLASSIFICATION REVIEW BOARD

The Secretary of HHS would be required to appoint a five-member Medicare Geographical Classification Review Board within 60 days of enactment. Two of the five members would be required to represent rural hospitals. One member would be a ProPAC member and one would be an expert in the field of hospital cost analysis.

The Board would consider applications from rural hospitals to be reclassified into a particular urban area. Applications would be due by January 31 of each calendar year, with a Board decision by June 1. Hospitals that are dissatisfied with the Board's decision could file an appeal with the Secretary. The appeals would be required to be filed by July 1, and the Secretary would be required to issue a final decision by September 1. There would be no judicial review. The Secretary could waive these deadlines in the case of extreme hardship.

If the Board finds that a rural hospital should be reclassified, that hospital will be paid as though it were located in the applicable urban area, and will be treated as an urban hospital for the purposes of inpatient hospital services and periodic interim payments.

The Secretary would be required to issue guidelines to be used by the Board in its deliberations by July 1, 1989. These criteria must include a comparison of wages between the applying hospital and hospital wages in the applicable urban area, a consideration of the effects on access to care by Medicare beneficiaries, and changes in the status of the county in which the rural hospital is located since the last decennial Census which might now qualify it for inclusion in an urban area.

SECTION 6: MODIFICATION IN GRANT PROGRAM FOR RURAL HEALTH CARE TRANSITION

Under the bill, the FY 1990 authorization for rural health care transition grants authorized by Section 4005 of the Omnibus Budget Reconciliation Act of 1987 would be increased from \$15 million to \$25 million, and would be extended for FY 1991 and 92 at the \$25 million level.

OBRA's limit of \$50,000 per grant each year would be waivable by the Secretary of HHS if he or she determines that a larger grant is required to implement a transition project.

Also, hospital applications for transition grants would no longer be submitted through the Governor's office, although a copy of this application would continue to be submitted to the Governor.

SECTION 7: INCREASE IN RURAL HEALTH MEDICAL EDUCATION DEMONSTRATION PROJECTS

The bill would expand the demonstration program created by Section 4038 of the Omnibus Budget Reconciliation Act of 1987, which increased Medicare payments to teaching hospitals for the costs of allowing resident physicians to develop field clinical experience in rural areas.

Under the bill, an additional 6 sponsoring teaching hospitals would be added to the four sites created by OBRA, for a period of three years.

SECTION 8: TREATMENT OF CERTAIN NURSING EDUCATION PROGRAMS

Under this provision, hospitals could qualify on a demonstration basis for expanded Medicare payments for training undergraduate (baccalaureate) nurses, where the hospital cooperates with a school of nursing by providing a setting for clinical training. (Medicare currently does not ordinarily recognize such cooperative arrangements and will pay nurse education costs only if the hospital is the sole operator of the training program.)

This provision, which builds on demonstrations of expanding graduate nurse training required by the Technical and Miscellaneous Revenue Act of 1988, would require a demonstration at five sites for five years, with a limit of \$200,000 annually at each site. Demonstration funds would be available for the medical education costs ordinarily recognized by Medicare (stipends, supervision, classroom costs) and only for years during or after which clinical training begins.

SECTION 9: TREATMENT OF REGIONAL REFERRAL CENTERS

This provision extends classification as a regional referral center for hospitals which qualify for that designation as of September 30, 1989. Regional referral center status would be continued through September 30, 1994, when a single national rate would be fully effective.

The provision also instructs the Secretary of HHS to use the average standardized amount applicable to discharges from a hospital located in a near-by urban area (other than a large urban area) in determining the amount payable for a discharge on or after October 1, 1989. Both provisions essentially protect the current status and payment for facilities qualified as regional referral centers.

Mr. PICKLE. Section 2 of this bill would eliminate the differential in average standardized payment amounts for hospitals in different areas. The Secretary of HHS would be required to design a legislative proposal to eliminate differing rates for rural and urban areas.

The proposal would allow a 4-year transition to a single national rate beginning in fiscal year 1992 with a single national rate fully in effect by 1995.

The Secretary will be required to include recommendations for any changes in Medicare's current special treatment of teaching hospitals, rural referral centers, sole community hospitals, disproportionate share hospitals and outlier cases.

Section 3 would provide that for a 2-year period rural hospitals with 100 or fewer beds and depend on Medicare for more than 70 percent of inpatient hospital services would receive an additional payment to ensure that total payments for inpatient hospital services would be equal to the reasonable costs of those services.

Section 4 of the bill would make modifications with respect to sole community hospitals similar to the changes these gentlemen just talked about.

Beginning October 1, 1989, Medicare payments on sole community hospitals would be changed. As you know, under current law SCHs are paid three-four on the basis of their own specific costs and one-four on the basis of the applicable regional PPS rate.

Under the proposed legislation, the three-four hospital specific cost basis would be updated by the Secretary of HHS using more recent information on the SCS cost per case. That update needs to be made.

Section 5 provides for establishment of a Medicare Geographical Classification Review Board. The Secretary of HHS would be required to appoint a five-member Medicare Geographical Classification Review Board within 60 days of enactment. Two out of five members would be required to represent rural hospitals and one member would be a ProPAC member, and one would be an expert in the field of hospital cost analysis.

I would make modifications in the program for rural health care transitions grants and I would expand the rural health medical education demonstration project. I would increase funding in those areas.

Mr. Chairman, I would ask that my entire statement be included in the record and I will submit a copy for the Secretary so that it can be entered.

May I say to you, Mr. Chairman, that though I come from an urban area, Austin, TX, with nearly a half million people, we are surrounded with thriving satellite cities all around. Hospitals in those towns are getting weaker and weaker, and people must rely on hospitals in urban areas.

I think we have to address those weaknesses so that we won't say to the rural resident, "You must go to the big city to go to the hospital." They are entitled to good care where they live.

We may have to make changes in four or five areas or more. I am not saying that the differential in payments is the only problem. Yet I notice every time a rural hospital closes there is a headline in the newspapers saying, "Medicare Closes Hospital," or "Hospital Closes Because Reimbursement is Not Sufficient Under Medicare." That is all they say, really. That is the headline and the emphasis.

It is more than that. Basically they cannot keep up with rising medical costs. They can't attract doctors to the hospital. They can't allow for nursing costs. There is no way to keep up with the latest medical equipment.

The community in a rural area must say to itself, we want a hospital and we will use a hospital and we will set it up so it will pay for itself. If they will do that, I think HCFA will cooperate with them.

I believe many Members of Congress recognize that there is an unfair differential between the rural and urban. We have to correct it and make some other corrections.

It is along those lines that I will be working. We have 100 members now pledged to do what they can to correct this.

Mr. Chairman, I know we will be working on this bill and others that have been referred to our committee. I thank you for the privilege of putting this in the record now.

[The bill, H.R. 762, follows:]

101ST CONGRESS
1ST SESSION

H. R. 762

To amend the Social Security Act to make certain modifications in the medicare program with respect to payments made under such program to hospitals located in rural areas, to improve the delivery of health services to individuals residing in such areas, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 2, 1989

Mr. PICKLE (for himself, Mr. ANTHONY, Mr. DOBGAN of North Dakota, Mr. FLIPPO, Mr. LAUGHLIN, Mr. ESPY, Mr. UPTON, Mr. ENGLISH, Mr. BOUCHER, Mr. YOUNG of Alaska, Mr. GRANT, Mr. McHUGH, Mr. STANGELAND, Mr. LANCASTER, Mr. SARPALIUS, Mr. SCHUETTE, Mr. LEATH of Texas, Mr. GUNDERSON, Mr. HALL of Texas, Mr. BARTON of Texas, Mr. EVANS, Mr. ROTH, Mr. TRAXLER, Mr. JOHNSON of South Dakota, Mr. STENHOLM, Mr. BAKER, Mr. CHAPMAN, and Mr. CRAIG) introduced the following bill; which was referred to the Committee on Ways and Means

A BILL

To amend the Social Security Act to make certain modifications in the medicare program with respect to payments made under such program to hospitals located in rural areas, to improve the delivery of health services to individuals residing in such areas, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

1 SECTION 1. SHORT TITLE.

2 This Act may be cited as the "Equity for Rural
3 Hospitals Act of 1989".

4 SEC. 2. ELIMINATION OF AVERAGE STANDARDIZED AMOUNTS
5 FOR HOSPITALS IN DIFFERENT AREAS AND
6 CREATION OF SEVERITY ADJUSTMENT.

7 (a) IN GENERAL.—The Secretary of Health and
8 Human Services (hereinafter referred to as the "Secretary")
9 or the designee of the Secretary shall design a legislative
10 proposal to eliminate the system of determining separate av-
11 erage standardized amounts for subsection (d) hospitals (as
12 defined in section 1886(d)(1)(B) of the Social Security Act)
13 classified as being located in large urban, other urban, or
14 rural areas under section 1886(d)(2)(D) of such Act. Such
15 proposal shall include—

16 (1) a transition period from the current system of
17 determining separate average standardized amounts to
18 a system based on one single rate beginning in fiscal
19 year 1992, with such single rate to be completely in
20 effect by fiscal year 1995;

21 (2) recommendations, where appropriate, for
22 modifying, eliminating, or maintaining additional pay-
23 ments or adjustments for teaching hospitals, rural re-
24 ferral centers, sole community hospitals, disproportion-
25 ate share hospitals, and outlier cases under title XVIII
26 of the Social Security Act; and for creating additional

1 payments or adjustments where deemed appropriate by
2 the Secretary;

3 (3) recommendations with respect to recalculating
4 standardized amounts to reflect information from a
5 more recent cost reporting period or periods;

6 (4) recommendations, where appropriate, for
7 modifying reimbursement for hospitals other than sub-
8 section (d) hospitals;

9 (5) a recommendation for a methodology to reflect
10 the severity of illness of different patients within the
11 same diagnosis related group (as determined in section
12 1886(d)(4)(B) of the Social Security Act); and

13 (6) an impact analysis of the proposed elimination
14 of separate average standardized amounts on hospitals
15 according to the following characteristics: urban or
16 rural (as defined in section 1886(d)(2)(D) of the Social
17 Security Act), teaching, disproportionate share, bed
18 size, medicare volume, sole community status, region,
19 and such other characteristics that the Secretary deems
20 significant.

21 (b) REPORT AND STUDY.—(1) The Secretary shall
22 submit a report (on the proposal described in subsection (a))
23 to the Congress no later than October 1, 1990.

24 (2) The report described in paragraph (1) shall be re-
25 viewed by the Prospective Payment Assessment Commission

1 and the Congressional Budget Office. The Prospective Pay-
2 ment Assessment Commission and the Congressional Budget
3 Office shall each submit a report including an impact analysis
4 as described in subsection (a)(6) containing the results of their
5 study to the Congress no later than April 1, 1991.

6 (c) EFFECTIVE DATE.—The provisions of this section
7 shall become effective upon the date of enactment of this Act.

8 SEC. 3. INTERIM PROVISION TO ENSURE ADEQUATE PAY-
9 MENTS FOR INPATIENT HOSPITAL SERVICES
10 FURNISHED BY MEDICARE-DEPENDENT,
11 SMALL, RURAL HOSPITALS.

12 (a) IN GENERAL.—Section 1886(d)(5) of the Social
13 Security Act (42 U.S.C. 1395ww(d)(5)) is amended by adding
14 at the end the following new subparagraph:

15 “(G)(i) For cost reporting periods beginning after Sep-
16 tember 30, 1989, and ending before October 1, 1991, the
17 Secretary shall provide for an additional payment amount for
18 each medicare-dependent, small, rural hospital (as defined in
19 clause (ii)) to ensure that the total of the payments made to
20 the hospital under this section (including this clause) for any
21 such cost reporting period is at least equal to the reasonable
22 costs associated with the hospital’s operating costs of inpa-
23 tient hospital services for medicare beneficiaries for that
24 period. In determining the reasonable costs of a hospital
25 under the previous sentence, the Secretary may not apply

1 limits which would limit reimbursement based on average
2 costs incurred by hospitals. In the case of a hospital receiving
3 payments on a periodic interim basis under section 1815(e)(1)
4 and entitled to additional payment amounts under this sub-
5 paragraph, such additional payment amounts shall be includ-
6 ed in the payments made under section 1815(e)(1).

7 “(ii) In clause (i), the term ‘medicare-dependent, small,
8 rural hospital’ means, for a cost reporting period with respect
9 to which such clause applies, a subsection (d) hospital—

10 “(I) that is receiving payments based on the rural
11 standardized amount and has no more than 100 beds;
12 and

13 “(II) for which period at least 70 percent of inpa-
14 tient hospital services (determined, at the hospital’s
15 option, on a per diem basis or on a discharge basis) are
16 attributable to inpatients who are entitled to benefits
17 under part A.”.

18 (b) EFFECTIVE DATE.—The amendment made by this
19 section shall become effective on the date of enactment of
20 this Act.

21 SEC. 4. MODIFICATIONS WITH RESPECT TO SOLE COMMUNITY
22 HOSPITALS.

23 (a) IN GENERAL.—Section 1886(d)(5)(C)(ii) of the
24 Social Security Act (42 U.S.C. 1395ww(d)(5)(C)(ii)) is
25 amended—

1 (1) by striking the first sentence and inserting the
2 following new sentence: "With respect to a subsection
3 (d) hospital which is a "sole community hospital", pay-
4 ment under paragraph (1)(A) for any cost reporting
5 period or fiscal year beginning on or after October 1,
6 1989, shall be equal to the sum of—

7 "(I) 75 percent of the greater of the hospi-
8 tal's target amount (as defined in subsection
9 (b)(3)(A), but determined without the application
10 of subsection (a)), or a target amount determined
11 by the Secretary in the same manner, but using
12 information from the most recent cost reporting
13 period or periods available; and

14 "(II) 25 percent of the greater of the appli-
15 cable regional or national DRG prospective pay-
16 ment rate determined under subsection (d)(3).";
17 and

18 (2) by adding at the end thereof the following new
19 sentence: "In determining the factors that constitute a
20 sole community hospital for purposes of the preceding
21 sentence the Secretary shall consider—

22 "(I) the time needed to travel to the nearest
23 alternative source of appropriate inpatient care;

24 "(II) in those cases where the Secretary de-
25 termines a hospital's eligibility for sole community

1 hospital status using criteria related to such hospi-
2 tal's share of beneficiaries eligible for benefits
3 under this title or total population of such benefi-
4 ciaries in the area served by the hospital, the Sec-
5 retary shall then take into account the total
6 number of patients (whether or not such patients
7 are eligible for benefits under this title) who seek
8 health services unavailable in the area served by
9 such hospital, without regard to the number of
10 beds in such hospital; and

11 "(III) such other factors that the Secretary
12 considers relevant."

13 (b) EFFECTIVE DATE.—The amendments made by this
14 section shall become effective upon the date of enactment of
15 this Act.

16 SEC. 5. ESTABLISHMENT OF MEDICARE GEOGRAPHICAL
17 CLASSIFICATION REVIEW BOARD.

18 (a) ESTABLISHMENT OF BOARD.—Section 1886(d) of
19 the Social Security Act (42 U.S.C. 1395ww(d)) is amended
20 by adding at the end thereof the following new paragraph:

21 "(10)(A) There is hereby established the 'Medicare Geo-
22 graphical Classification Review Board' (hereinafter in this
23 paragraph referred to as the 'Board').

24 "(B)(i) The Board shall be composed of 5 members ap-
25 pointed by the Secretary without regard to the provisions of

1 title 5, United States Code, governing appointments in the
2 competitive service. Two of such members shall be represent-
3 atives of subsection (d) hospitals classified as located in an
4 rural area under paragraph (2)(D). At least 1 member shall
5 be a member of the Prospective Payment Assessment Com-
6 mission, and at least 1 member shall be knowledgeable in the
7 field of analyzing costs with respect to the provision of inpa-
8 tient hospital services.

9 “(ii) The Secretary shall make all appointments to the
10 Board as provided in this paragraph within 60 days after the
11 date of the enactment of the Equity for Rural Hospitals Act
12 of 1989.

13 “(C)(i) The Board shall consider the application of—

14 “(I) any subsection (d) hospital, or

15 “(II) any subsection (d) Puerto Rico hospital,
16 located in a rural area requesting that the Board classify such
17 hospital as a hospital located in an urban area for purposes of
18 determining the hospital's average standardized amount
19 under paragraph (2)(D). Such application shall specify which
20 Metropolitan Statistical Area the requesting hospital would
21 like to be classified in, and shall be submitted no later than
22 January 31, of the year in which such hospital requests
23 reclassification.

24 “(ii)(I) The Board shall render a decision either accept-
25 ing or denying the application of a hospital located in a rural

1 area to be reclassified as a hospital located in a urban area by
2 June 1, of the year in which such applying hospital submits
3 an application as described in this paragraph. The Board in
4 rendering such decision shall take into consideration and
5 make specific findings on the record regarding the criteria
6 published by the Secretary as described in subparagraph (D).

7 “(II) A decision of the Board shall be final unless the
8 unsuccessful applicant appeals such decision to the Secretary
9 by July 1, of the year in which such applicant unsuccessfully
10 applied for reclassification pursuant to this paragraph. The
11 Secretary in considering the appeal of an applicant shall re-
12 ceive no new evidence but shall consider the record as a
13 whole as such record appeared before the Board. The Secre-
14 tary shall issue a decision either affirming or reversing the
15 decision of the Board by September 1, of the year in which
16 such unsuccessful applicant appeals a decision of the Board
17 pursuant to this section. The decision of the Secretary in
18 either affirming or reversing the decision of the Board shall
19 be final and shall not be subject to judicial review.

20 “(iii) A decision of the Board or a decision of the Secre-
21 tary, if a decision of the Board is appealed to the Secretary,
22 shall become effective on October 1 of the year in which such
23 decision is rendered, and if such decision is in favor of the
24 applying hospital, such hospital shall be reclassified by the

1 Secretary as being located in an urban area for purposes of
2 subsection (d) and section 1815 (e)(1).

3 “(D)(i) The Secretary shall publish guidelines to be uti-
4 lized by the Board in rendering decisions on the applications
5 of applying hospitals. Such criteria to be published by the
6 Secretary shall include the following:

7 “(I) A comparison of wages, taking into account
8 occupational mix, between a hospital located in a rural
9 area applying for reclassification as a hospital located
10 in a urban area, and hospitals located in the urban area
11 into which such applying hospital would be reclassified.

12 “(II) An examination of whether the applying
13 hospital is located in a county that, on the basis of the
14 most recent data published by the Bureau of the
15 Census, meets requirements of the Office of Manage-
16 ment and Budget for inclusion as an outlying county of
17 a Metropolitan Statistical Area, without regard to any
18 requirement by the Office of Management and Budget
19 that certain data for qualification be from the decennial
20 census.

21 “(III) Consideration of the effects on access to in-
22 patient hospital services by medicare beneficiaries
23 should an applying hospital not be reclassified as
24 urban.

1 “(ii) The Secretary shall publish the criteria described in
2 clause (i) by July 1, 1989.

3 “(E)(i) The Board shall have full power and authority to
4 make rules and establish procedures, not inconsistent with
5 the provisions of this title or regulations of the Secretary,
6 which are necessary or appropriate to carry out the provi-
7 sions of this paragraph. In the course of any hearing the
8 Board may administer oaths and affirmations. The provisions
9 of subsections (d) and (e) of section 205 with respect to sub-
10 poenas shall apply to the Board to the same extent as such
11 provisions apply to the Secretary with respect to title II.

12 “(ii) The Board is authorized to engage such technical
13 assistance and to receive such information as may be required
14 to carry out its functions, and the Secretary shall, in addition,
15 make available to the Board such secretarial, clerical, and
16 other assistance as the Board may require to carry out its
17 functions.

18 “(F)(i) Each member of the Board who is not an officer
19 or employee of the Federal Government shall be compensat-
20 ed at a rate equal to the daily equivalent of the annual rate of
21 basic pay prescribed for grade GS-18 of the General Sched-
22 ule under section 5332 of title 5, United States Code, for
23 each day (including travel time) during which such member is
24 engaged in the performance of the duties of the Board. All
25 members of the Board who are officers or employees of the

1 United States shall serve without compensation in addition to
2 that received for their services as officers or employees of the
3 United States.

4 “(ii) The members of the Board shall be allowed travel
5 expenses, including per diem in lieu of subsistence, at rates
6 authorized for employees of agencies under subchapter I of
7 chapter 57 of title 5, United States Code, while away from
8 their homes or regular places of business in the performance
9 of services for the Board.”.

10 (b) EFFECTIVE DATE.—The provisions of this section
11 shall become effective upon the date of enactment of this Act.

12 SEC. 6. MODIFICATIONS IN GRANT PROGRAM FOR RURAL
13 HEALTH CARE TRANSITION.

14 (a) IN GENERAL.—Section 4005(e) of the Omnibus
15 Budget Reconciliation Act of 1987 is amended—

16 (1) in paragraph (3)(A) by inserting “to the
17 Administrator and a copy of such application” after
18 “an application”;

19 (2) in paragraph 3(b) by striking “any application”
20 and all that follows through “accompanied by” and in-
21 serting in lieu thereof “to the Secretary”;

22 (3) in paragraph (6) by striking “A grant” and all
23 that follows through “2 years” and inserting in lieu
24 thereof the following: “A grant to a hospital under this
25 subsection may not exceed \$50,000 a year, unless the

Secretary determines that an amount in excess of \$50,000 a year is necessary to assist a hospital receiving such a grant in implementing a project as described in paragraph (1). A grant to a hospital under this subsection may not exceed 3 years"; and

(4) in paragraph (9) by striking "\$15,000,000 for each of the fiscal years 1989 and 1990" and inserting in lieu thereof "\$25,000,000 for each of the fiscal years 1990, 1991, and 1992".

(b) EFFECTIVE DATE.—The amendments made by this section shall become effective on October 1, 1989.

SEC. 7. INCREASE IN RURAL HEALTH MEDICAL EDUCATION
DEMONSTRATION PROJECTS.

(a) IN GENERAL.—Section 4038 of the Omnibus Budget Reconciliation Act of 1987 is amended—

(1) in subsection (a) by striking "enter into agreements with four sponsoring" and all that follows through "rural areas" and inserting in lieu thereof the following: "enter into agreements—

"(1) with 4 sponsoring hospitals submitting applications under this subsection; and

"(2) with 10 sponsoring hospitals submitting applications under this subsection without regard to the requirements contained in subsection (c),

1 to conduct demonstration projects to assist resident physi-
2 cians in developing field clinical experience in rural areas.”;

3 (2) in subsection (c) by striking “subsection (a)”
4 and inserting in lieu thereof “subsection (a)(1)”; and

5 (3) in subsection (e) by striking “Each demonstra-
6 tion project” and all that follows through “three
7 years” and inserting in lieu thereof the following:

8 “Each demonstration project under—

9 “(1) subsection (a)(1) shall be commenced not
10 later than 6 months after the date of enactment of
11 this Act, and

12 “(2) subsection (a)(2) shall be commenced not
13 later than 6 months after the date of enactment of
14 the Equity for Rural Hospitals Act of 1989, and
15 shall be conducted for a period of 3 years.”.

16 (b) EFFECTIVE DATE.—The amendments made by this
17 section shall become effective on the date of enactment of
18 this Act.

19 SEC. 8. TREATMENT OF CERTAIN NURSING EDUCATION PRO-
20 GRAMS.

21 (a) DEMONSTRATION OF JOINT NURSING UNDER
22 GRADUATE EDUCATION PROGRAMS.—

23 (1) The Secretary of Health and Human Services
24 shall provide for demonstration programs under this
25 subsection in each of 5 hospitals for cost reporting pe-

1 riods beginning on or after July 1, 1990, and before
2 July 1, 1995.

3 (2) Under each demonstration project, subject to
4 paragraph (4), the reasonable costs incurred by a hos-
5 pital pursuant to a written agreement with an educa-
6 tional institution for the activities described in para-
7 graph (3) conducted as part of an approved educational
8 program that leads to a bachelor's degree in nursing,
9 shall be allowable reasonable costs under title
10 XVIII of the Social Security Act and reimbursed
11 under such title on the same basis as if they were al-
12 lowable direct costs of a hospital-operated approved
13 educational program (other than an approved graduate
14 medical education program).

15 (3) The activities described in this paragraph are
16 the activities for which the reasonable costs of conduct-
17 ing such activities are allowable under title XVIII of
18 the Social Security Act if conducted under a hospital-
19 operated approved educational program (other than an
20 approved graduate medical education program), but
21 only to the extent such activities—

22 (A) are directly related to the operation of
23 the educational program conducted pursuant to
24 the written agreement between the hospital and
25 the educational institution; and

1 (B) take place in a year of an undergraduate
2 nursing program during or after which clinical
3 training has begun.

4 (4) The amount paid under a demonstration pro-
5 gram under this subsection to a hospital for a cost re-
6 porting period may not exceed \$200,000.

7 (5) The Secretary shall report to the Congress, by
8 not later than January 1, 1996, on the demonstration
9 programs conducted under this subsection and on the
10 supply and characteristics of nurses trained under such
11 programs.

12 (b) EFFECTIVE DATE.—The provisions of this section
13 shall take effect upon the date of enactment of this Act.

14 SEC. 9. TREATMENT OF REGIONAL REFERRAL CENTERS.

15 (a) EXTENSION OF REGIONAL REFERRAL CENTER
16 CLASSIFICATION.—Any hospital that is classified as a re-
17 gional referral center under section 1886(d)(5)(C)(i) of the
18 Social Security Act as of September 30, 1989, including a
19 hospital so classified as a result of section 9302(d)(2) of the
20 Omnibus Budget Reconciliation Act of 1986, shall continue
21 to be classified as a regional referral center for cost reporting
22 periods beginning on or after October 1, 1989, and before
23 October 1, 1994.

24 (b) CONTINUATION OF PAYMENT RATE.—In determin-
25 ing the amount that is payable under section 1886(d) of the

1 Social Security Act for a discharge on or after October 1,
2 1989, from a hospital that is classified as a regional referral
3 center for purposes of payment under such section, the Secre-
4 tary of Health and Human Services shall use the average
5 standardized amount that is applicable to discharges from a
6 hospital that is located in an urban area (other than a large
7 urban area) in the region in which the hospital so classified is
8 located (as such terms are used in such section).

Chairman STARK. I want to thank the distinguished gentleman. If he has it available, I would like to keep the record open for revenue estimates, because I am sure we will be discussing this as we work on the reconciliation package.

If he does not have that yet, I would encourage him to get it to CBO so we can have that priced out for us.

Mr. PICKLE. We will be asking for those cost figures, too.

Chairman STARK. Thank you very much.

That concludes today's hearing.

[Whereupon, at 5:40 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

TESTIMONY OF THE ILLINOIS HOSPITAL ASSOCIATION
BEFORE THE SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
OF THE U.S. HOUSE OF REPRESENTATIVES
MAY 15, 1989

THE ILLINOIS HOSPITAL ASSOCIATION (IHA) ON BEHALF OF ITS MEMBERS, APPRECIATES THE OPPORTUNITY TO TESTIFY BEFORE THE HOUSE WAYS & MEANS SUBCOMMITTEE ON HEALTH REGARDING THE FISCAL YEAR 1990 BUDGET, PARTICULARLY AS IT PERTAINS TO MEDICARE PART A PAYMENTS TO RURAL AND INNER-CITY HOSPITALS. IN ILLINOIS, THERE ARE 85 RURAL HOSPITALS AND 138 URBAN HOSPITALS, INCLUDING 49 THAT COULD BE CLASSIFIED AS INNER-CITY HOSPITALS.

INNER-CITY HOSPITALS CANNOT REMAIN FINANCIALLY HEALTHY IN THE CURRENT ENVIRONMENT. ON AVERAGE, ILLINOIS HOSPITALS RECEIVE 84 CENTS ON THE COST DOLLAR FOR SERVICES TO MEDICARE BENEFICIARIES; INNER-CITY HOSPITALS ARE PAID EVEN LESS. THE ILLINOIS MEDICAID PROGRAM, ON AVERAGE, PAYS HOSPITALS 63 CENTS ON THE COST DOLLAR. THERE ARE CURRENTLY 1.8 MILLION ILLINOISANS WITHOUT HEALTH INSURANCE AND HOSPITALS RENDERED NEARLY \$600 MILLION IN UNCOMPENSATED CARE LAST YEAR. THE COMBINATION OF THESE THREE FACTORS HAVE CLOSED 10 INNER-CITY HOSPITALS SINCE 1986; 7 WERE IN HEALTH MANPOWER SHORTAGE AREAS. IN ADDITION, OPERATING COSTS ARE HIGHER IN THE CITY BECAUSE THEY HAVE COSTS THAT OTHER AREAS DO NOT HAVE; SUCH AS THE NEED FOR SECURITY SERVICES.

A RECENTLY PUBLISHED STUDY ESTIMATING MEDICARE OPERATING MARGINS IN FY 1990 SHOWS ILLINOIS HOSPITALS WILL HAVE A 16.6% OPERATING LOSS FOR MEDICARE PATIENTS.

THE MEDICARE PROGRAM WAS CLEARLY NOT DESIGNED ADEQUATELY TO ASSURE THAT HOSPITALS IN AREAS LIKE CHICAGO AND OTHER MAJOR METROPOLITAN AREAS, CONSISTING OF THE INNER-CITY AND SUBURBAN RING, RECEIVE THE NECESSARY DIFFERENTIATING COST REIMBURSEMENT TO SURVIVE. THE RESULT AS STATED PREVIOUSLY IS 10 INNER-CITY HOSPITALS BEING FORCED INTO BANKRUPTCY.

RURAL ILLINOIS HOSPITALS ARE ALSO FINDING IT NEARLY IMPOSSIBLE TO PROVIDE NECESSARY CARE TO MEDICARE BENEFICIARIES WHEN THE AVERAGE MEDICARE REIMBURSEMENT IN ILLINOIS IS 84 CENTS ON THE DOLLAR AND RURAL HOSPITALS RECEIVE EVEN LESS.

ILLINOIS HAS SEEN 6 RURAL HOSPITALS CLOSE SINCE 1986, DUE IN A LARGE MEASURE TO THE INADEQUATE MEDICARE REIMBURSEMENT LEVEL. FOR MOST OF THESE RURAL HOSPITALS, MEDICARE PATIENTS REPRESENT MORE THAN HALF OF THEIR TOTAL PATIENTS. HOSPITALS THAT ALSO HAVE A HIGH PERCENTAGE OF MEDICAID PATIENTS, THAT ON AVERAGE THE STATE REIMBURSES 63 CENTS ON THE COST DOLLAR, JUST CANNOT REMAIN FINANCIALLY VIABLE. RURAL HOSPITALS, DUE TO THE SCARCITY OF PHYSICIANS AND ALLIED HEALTH PROFESSIONALS ARE HARD PRESSED TO ATTRACT AND RETAIN THESE PROFESSIONALS. THE MEDICARE AREA WAGE INDEX, PROPOSED FOR FY 90, FOR ILLINOIS RURAL HOSPITALS IS .8002, WHICH DOES NOT ADEQUATELY REFLECT THE CURRENT WAGE ENVIRONMENT. IN ADDITION, THE NATIONAL STANDARDIZED LABOR-RELATED RATE IS 7% LOWER FOR RURAL THAN FOR LARGE URBAN AND THE NONLABOR-RELATED STANDARDIZED RATES ARE 34% LOWER. THE COST SPREAD BETWEEN STANDARDIZED RATES IS EVEN WIDER FOR HOSPITALS IN THIS REGION.

IHA TESTIMONY

Page 2

IT IS CLEAR THAT THESE RURAL HOSPITALS CANNOT CONTINUE TO SURVIVE WITH THE INADEQUATE REIMBURSEMENT LEVELS FROM MEDICARE, MEDICAID AND THE GROWING POPULATION OF THE UNINSURED. AS A RESULT, RURAL HOSPITALS HAVE BEEN FORCED TO SCALE BACK SERVICES.

WHAT IS CLEARLY NEEDED IS A RECOGNITION OF THE PROBLEM AND THEN A VIABLE SOLUTION MUST BE FOUND. THIS COMMITTEE, IN RECOGNIZING THIS PROBLEM, ESTABLISHED SEPARATE UPDATE FACTORS FOR RURAL AND LARGE URBAN AREAS. THIS ACT WAS MODEST IN NATURE, BUT WAS CLEARLY A STEP IN THE RIGHT DIRECTION.

STATEMENT OF
MARTHA MCSTEEN

PRESIDENT OF THE

NATIONAL COMMITTEE TO PRESERVE
SOCIAL SECURITY AND MEDICARE

My name is Martha McSteen and I am President of the National Committee to Preserve Social Security and Medicare. Many of the National Committee's five million members live in rural and inner city areas and so have a stake in the survival of local hospitals if they are going to have access to health care. Many of the problems of inner city hospitals are similar to the problems of rural hospitals and the National Committee would support efforts to resolve the problems of both groups of hospitals. Our specific recommendations today, however, relate directly to the problems of rural hospitals.

The National Committee endorses the Equity for Rural Hospitals Act (H.R. 762), which was introduced by your colleague, Rep. Pickle, and pledges to work to bring health care relief to rural communities around the country. Most important is the elimination of the 13 percent lower reimbursement rate for rural hospitals as soon as possible.

Concern for the state of rural health care is more than justified. During this decade, six percent of the nation's rural hospitals had to close their doors. Even more frightening is the statistic Senator Bentsen has quoted that as many as 600 hospitals, more than 20 percent of all rural hospitals, will shut down in the next five years. If this is allowed to happen, access to health care for seniors, especially for the poor, will decline dramatically.

Many lay the blame for these hospital failures on poor financial management and "inefficiencies." This may be true in some cases. However, research by the Senate Special Committee on Aging during the 100th Congress clearly documents that many of the closings are due to flaws in the Medicare reimbursement system which penalize rural hospitals and to the failure of the reimbursement system to take into account special conditions faced by rural hospitals. The Equity for Rural Hospitals Act would address the immediate problems and lay the groundwork for further reforms through additional studies and demonstration projects.

Eliminating Payment Differentials

Congress can no longer justify lower payments to rural hospitals. Most operating costs do not vary significantly between rural and urban areas. In fact, small rural hospitals frequently do not receive volume discounts and face higher transportation costs than some urban hospitals. We support efforts to eliminate this payment differential as soon as possible.

While a lower wage scale may exist for some rural hospitals, some rural hospitals compete for labor in a market that includes urban areas and wage scales. So we are as disappointed as you that the Administration has failed to exercise its administrative authority to grant relief to rural hospitals in this situation. However, we are not surprised that the Administration has ignored this inequity in favor of saving money. No wonder it is necessary to create a Medicare Geographic Classification Board to review hospital complaints about the geographic classification.

Interim Payments to Vulnerable Rural Hospitals

Those hospitals most vulnerable have less than 100 beds and are dependent on Medicare for a substantial portion of their revenue. They need additional guarantees, at least on an interim basis, that Medicare reimbursements will cover reasonable costs. Medicare pays hospitals a fixed

fee for each patient according to the diagnosis but ignores severity of illness. With a high reliance on Medicare patients for revenue and a low volume of patients, most small rural hospitals do not have the financial leeway of larger hospitals to absorb the high cost of treating the few severely ill patients. We hope that you will explore further whether the eligibility criteria will provide protection to all small rural hospitals who would need this protection. The Equity for Rural Hospitals Act would limit the guarantees to small rural hospitals dependent on Medicare for more than 70 percent of their revenue. Rep. Dorgan has proposed liberalizing the criteria to include small rural hospitals dependent on Medicare for more than 55 percent of their revenue. Even the more liberal eligibility criteria would only cover about 3.5 percent of rural hospitals, according to data from the American Hospital Association.

Innovative Ideas

The National Committee strongly endorses creative approaches to providing health care in rural areas. Not only are local conditions in many rural communities different than in the nation as a whole, but rural society is changing dramatically. Yet one of the problems of a national health care program is the difficulty in responding to local conditions and changes in society. Medicare must make a conscious effort to be adaptable and to encourage experimentation in health care delivery through demonstration projects such as the ones authorized by your legislation.

Need for Additional Studies

A number of studies are necessary to fully analyze the fairness of the Medicare reimbursement system for rural hospitals and to develop a methodology for eliminating payment differentials. The timeliness of these reports is essential to enable Congress to eliminate payment differentials as soon as possible. Unfortunately, the Administration's track record on completing these reports in a timely manner leaves something to be desired. For example, we are disappointed that Congress must legislate once again to direct the Secretary of Health and Human Services to develop a methodology to reflect the severity of illness of different patients within the same Diagnosis Related Group. Congress first asked the Secretary for this report in 1986 legislation to improve the quality of care for Medicare patients in hospitals. The report is now six months overdue.

Increase Health Care Professionals in Rural Areas

Efforts to protect rural hospitals must go hand in glove with efforts to attract health care professionals to rural areas. The National Committee supports demonstration projects designed to expose doctors and nurses to rural health care experiences. We hope that your Subcommittee would consider other proposals to attract health care professionals to rural areas.

Conclusion

The National Committee is looking forward to legislation this year to help bring relief to rural communities around the country. The Equity for Rural Hospitals Act is a promising start.

SUBMITTED TO THE
HONORABLE FORTNEY PETE STARK (D-CALIFORNIA), CHAIRMAN
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES

ON PART A OF THE MEDICARE PROGRAM
FISCAL YEAR 1990 BUDGET ISSUES

Submitted by
THE NATIONAL FEDERATION OF HOUSESTAFF ORGANIZATIONS
David Daigneault, M.D., President
386 Park Avenue South, Room 1502
New York, NY 10016

May 15, 1989

The National Federation of Housestaff Organizations represents organized housestaff throughout the country. Since the formation of NHO our members have been leaders in community, state and national efforts to improve patient care and hospital conditions.

Medicare is a key source of funding for residency programs. These physicians in training spend nearly 90% of their working time providing essential patient care services, primarily in hospitals which serve the poor.

This year proposed Medicare cuts reach \$2.7 billion, affecting indirect medical education, capital expenditures and attending physician payments.

Before the onset of DRGs, the significant amount of care for the nation's poor provided by teaching hospitals was covered through hidden cross subsidies. By acknowledging the increased costs of teaching and urban hospitals, Congress acknowledged that residency programs played a vital role in meeting a social need: providing access to health care for all Americans, regardless of income.

Very quickly, however, the indirect payments to teaching hospitals, designed to compensate these hospitals in part for the higher costs of serving the poor, came under attack.

In 1983, when the system of prospective payments began, teaching hospitals received an 11.3% additional adjustment, cut to 8.1% in 1986, and 7.7% in FY89. The Bush administration now proposes a cut to 4.05% for FY90, affecting some 800 teaching hospitals, those in urban areas the hardest. The Health and Hospitals Corporation in New York City estimates that their hospitals will lose \$20 million if the federal cuts are adopted.

Cuts in these indirect payments dismantle the current system of training physicians and meeting patient care needs without building positive alternatives. Teaching hospitals provide every kind of essential medical service. For example, New York City's public hospitals provide over 5 million outpatient visits a year to the city's poor and uninsured. This is in addition to inpatient care, which often runs at over 100% bed occupancy rates. Boston City Hospital, where I work, has had occupancy rates as high as 124%. Patients can spend up to a week in emergency rooms on stretchers and gurnies while waiting for beds. The physicians of these patients are, for the most part, residents. If funding for residency programs are cut, who will see these patients? The "savings" estimated in the federal budget will be short-lived, because someone will have to be paid to care for these patients.

In the midst of cost-containment and budget-cutting strategies, Congress should protect funds such as the indirect payment and the disproportionate share adjustment is essential to teaching hospitals serving higher proportions of the medically indigent.

Given the cuts already made in the indirect payments for residency programs, Congress should avoid more cuts. Furthermore, the disproportionate share adjustment should be increased so that the hospitals which are stretched to the limits get the support they need.